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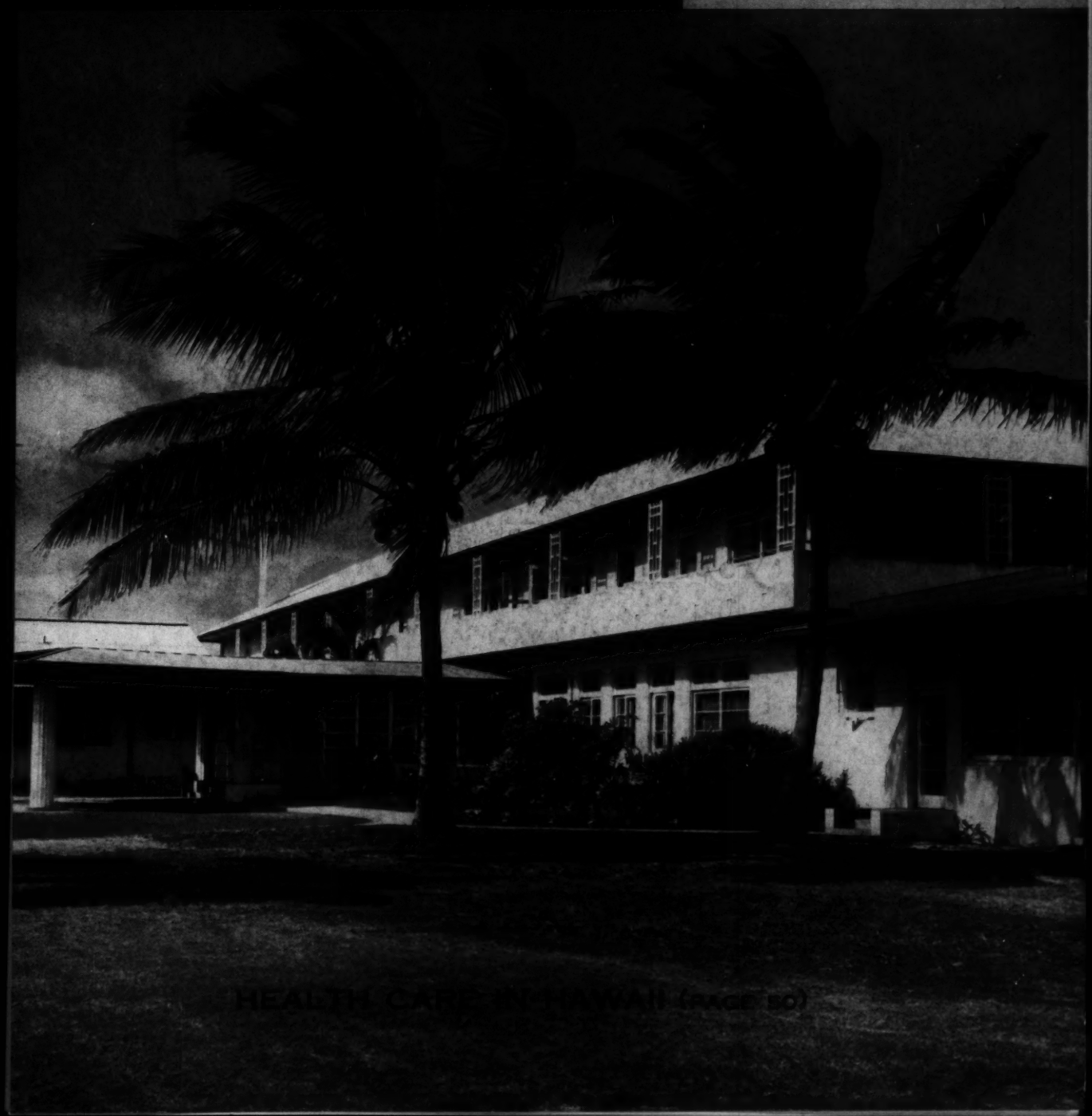
HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

MAY 16, 1959



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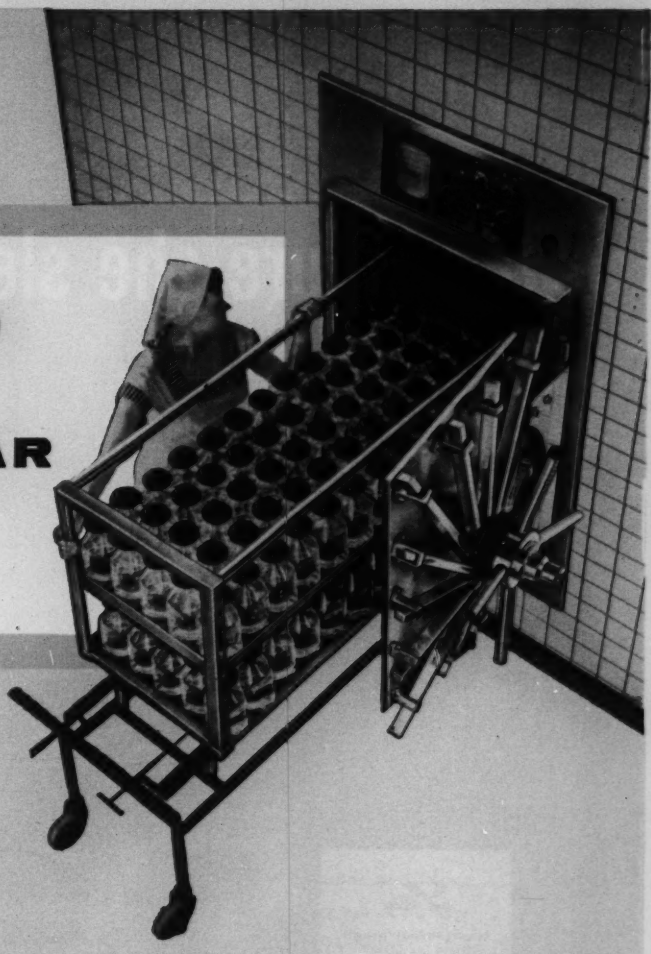

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Journal of the American Hospital Association

Volume 33 **Number 10** **May 16, 1959**

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The G. N. Wilcox Memorial Hospital, on the island of Kauai, is one of the many modern hospitals serving the "state-to-be" of Hawaii. An article by the administrator of Hawaii's first hospital describing the hospital and health situation in Hawaii today begins on page 50. Photo by Senda Photo Supply Co. (Other picture credits on page 148.)

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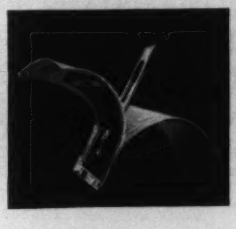
What every Purchasing Agent should know about A·S·R SteriSharps blades

Q. *What are SteriSharps?*



A. They are sterile-packed surgical blades made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments they will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharps blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharps packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharps packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharps blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharps blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

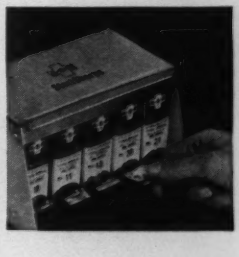
Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharps does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*



A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. H, 380 MADISON AVENUE, NEW YORK 17, N. Y.

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hospital association meetings

AMERICAN HOSPITAL ASSOCIATION NATIONAL MEETINGS

1959

July 6-10 **Summer Conference for Hospital Association Directors,** Chicago (AHA Headquarters)

Aug. 24-27—**61st annual meeting,** New York City (Coliseum; Statler Hotel)

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium)

MEETING AND INSTITUTE CALENDAR

THROUGH OCTOBER 1959

(American Hospital Association institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

MAY

18-20 Arkansas Hospital Association, Hot Springs (Arlington Hotel)

18-21 **Hospital Dental Service,** San Francisco (Sheraton-Palace Hotel)

20-22 Middle Atlantic Hospital Assembly, Atlantic City (Convention Hall)

20-22 New Jersey Hospital Association, Atlantic City (Convention Hall)

20-22 Hospital Association of New York State, Atlantic City (Convention Hall)

20-22 Hospital Association of Pennsylvania, Atlantic City (Convention Hall)

24-29 ***National Tuberculosis Association,*** Chicago (Palmer House)

25-27 **Hospital Law,** Boston (Somerset Hotel)

25-29 **Nursing Service Administration,** Cleveland (Pick Carter Hotel)

JUNE

1-3 ***American National Red Cross,*** Atlantic City, N. J.

1-3 **Advanced Institute for Medical Record Librarians,** Chicago (AHA Headquarters)

1-4 Catholic Hospital Association, St. Louis (Kiel Auditorium)

1-6 ***International Hospital Congress,*** Edinburgh, Scotland

2-3 Maine Hospital Association, Rockland (Samoset Hotel)

4-5 ***American Geriatrics Society,*** Atlantic City, N. J.

5 Connecticut Hospital Association, Newington (Connecticut Light and Power Co.)

8-10 **Administrators' Secretaries,** Chicago (AHA Headquarters)

8-12 ***American Medical Association,*** Atlantic City, N. J. (Convention Hall)

10-12 North Carolina Hospital Association, Blowing Rock (Mayview Manor)

12-14 ***Joint Council to Improve the Health Care of the Aged,*** Washington, D. C. (Sheraton Park Hotel)

15-19 **Hospital Pharmacy,** Salt Lake City (University of Utah, Union Building)

18-19 New Hampshire Hospital Association, Whitefield (Mountain View House)

21-23 Michigan Hospital Association, Detroit Sheraton-Cadillac Hotel)

24-26 Comite des Hopitaux du Quebec, Montreal (Showmart)

JULY

13-17 **Hospital Purchasing,** Chicago (AHA Headquarters)

13-17 **Workshop on Team Nursing,** Chicago (AHA Headquarters)

AUGUST

3-7 **Hospital Pharmacy,** Chicago (University of Chicago)

23-26 ***American College of Hospital Administrators,*** New York City (Statler-Hilton Hotel)

24-27 ***American Association for Hospital Planning,*** New York City (Governor Clinton Hotel)

24-27 ***American Association of Hospital Consultants,*** New York City, (Statler-Hilton Hotel)

24-27 ***American Association of Nurse Anesthetists,*** New York City (New Yorker Hotel)

25-28 ***American Dietetic Association,*** Los Angeles (Shrine Auditorium)

SEPTEMBER

3-9 ***American Psychological Association,*** Cincinnati

(Continued on page 138)

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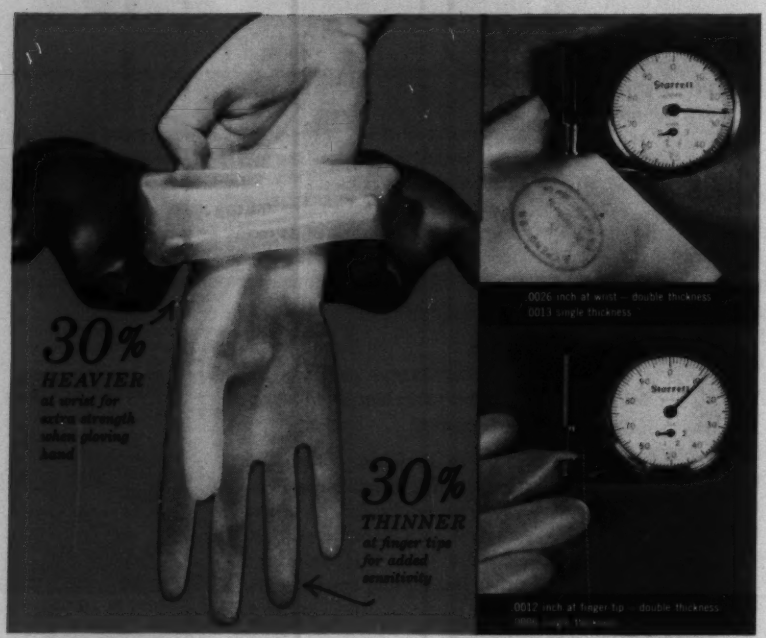
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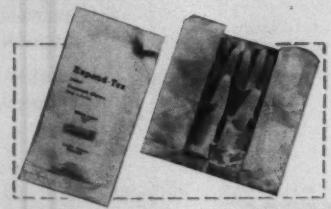

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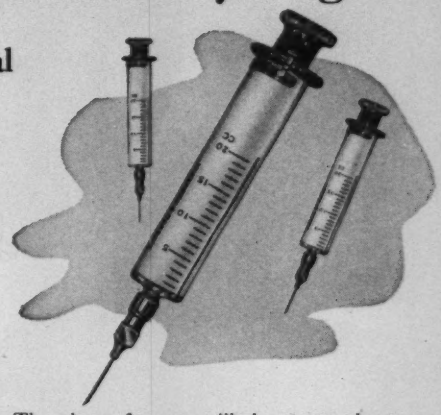
How Not to Get Stuck with Syringes

A report on the Economical stocking of Hypodermic Syringes by the hospital



by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.

Hypodermic syringes are high on the hospital pharmacy list of inventory "troublemakers." The following questions and answers are designed as a guide to make your syringe inventory operation as economical, and therefore profitable, as possible.

1. Should I buy disposable syringes or re-usable syringes?

To answer this question, you must determine the exact costs involved in rendering a glass hypodermic syringe usable after each use, including the available help on the floors as well as in Central Supply, and also the cost of processing a purchase order.

2. How much does it cost to buy hypodermic syringes?

Several studies show the cost of processing a purchase order to be anywhere from $4-$14. Procurement costs consist of the time and money spent in replenishment studies, purchase actions, receiving stock, inspecting stock and, of course, paying for stock. You can reduce procurement costs by placing fewer orders and buying larger quantities, but there is a direct proportion between procurement costs and carrying costs. Placing fewer and larger orders automatically increases carrying costs.

3. How much does it cost to stock hypodermic syringes?

Carrying costs consist of elements such as storage, obsolescence, loss through theft or damage and deterioration. Many industrial concerns calculate annual carrying costs at between 10% and 30% of the initial cost. Since the average hospital uses 10¢ per bed per day of syringes, obviously even a minimum 10% carrying cost will affect operating costs and, thus, profit.

4. How does the value of orders determine total costs?

Value of Order	No. of Orders Per Year	Procurement Costs	Average Active Inventory	Carrying Costs	Total Cost
$ 1200	1	$ 4	$ 600	$ 60	$ 64
600	2	8	300	30	38
400	3	12	200	20	32
300	4	16	150	15	31*
240	5	20	120	12	32
200	6	24	100	10	34

Least Total Cost

5. When should I buy hypodermic syringes?

Many buyers ask, "How many syringes should I buy?" The real problem is not so much *how many* but *when* to buy. The when, of course, will also answer the question of how much. After your total costs of procuring and carrying are established, the resulting data will give you the economic purchase order quantity, or the number of times per year an order should be placed.

6. What is the economic purchase order quantity?

Economic purchase order quantity is the level at which the combined costs of procuring and carrying inventory are at a minimum. The size of the order which produces this result is known as the Economic Purchase Order Quantity.

7. What is a desired "Stock Turnover" as related to syringes?

Stock turnover is calculated by dividing the cost of sales by the cost of inventory. For example, if your cost of sales is $40,000 and your cost of inventory is $10,000, you are getting 4 stock turns per year. If, however, you wish to achieve a desired stock turnover of 5 per year, then $40,000 divided by 5 ($8,000) should be cost of inventory. The desirable stock turnover depends upon the value of the order, as shown in the chart under question #4.

8. How can McKesson & Robbins help alleviate your syringe problems?

With smaller inventories naturally comes the greater volume of turnover necessary for profitable operations. McKesson & Robbins Hospital Service Department helps make smaller inventories possible through its fast delivery service. With 82 warehousing units located strategically throughout the country, a local source of supply is available any hour of day or night for emergency deliveries as well as routine service.

In addition, McKesson offers its own outstanding line of hypodermic syringes and needles, as well as other pharmaceutical items. McKesson is now offering an invaluable free booklet entitled, "How to Prolong the Life of Hypodermic Syringes." We would be pleased to send it to you, as well as the name of the McKesson Hospital Service Department nearest you. Your McKesson representative will be glad to discuss your business problems with you, as well as your syringe care, cleaning and maintenance problems—at no obligation. Address your inquiry to: A. A. Mannino, McKesson & Robbins, Inc., 155 East 44th St., New York 17, New York.

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All these B.F.Goodrich products made of Koroseal flexible material are sold by hospital supply houses and surgical dealers. For a catalog, a Koroseal sheeting swatch book or additional information, write: *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

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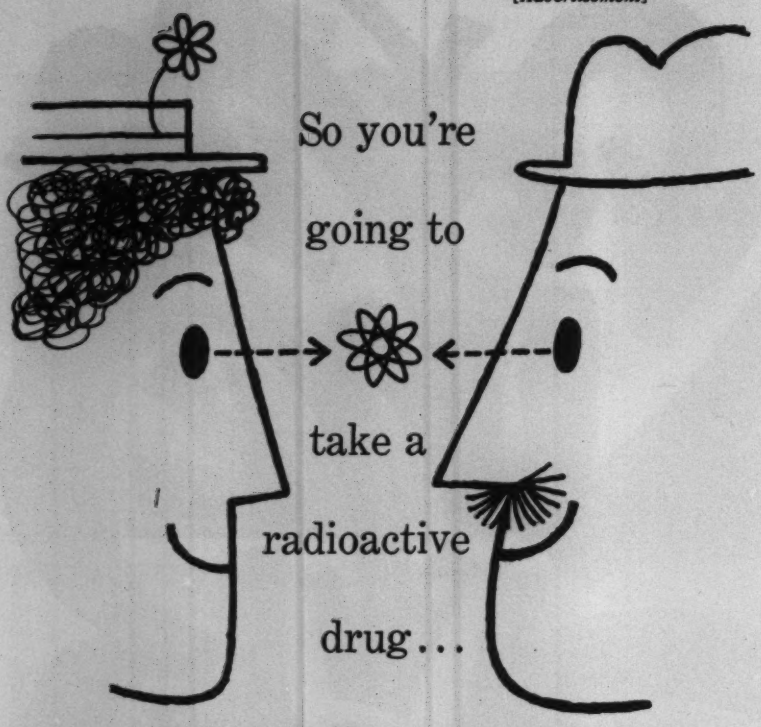


This text, taken from a recent Abbott leaflet, was prepared in response to requests from doctors who use radioisotopes (or who refer patients). It is designed to help the doctor inform and reassure his patient in simple, non-medical terms. Since this material has been well received, Abbott believes others in the medical profession may find it of interest. The leaflet is reproduced here in its entirety. Abbott

PIONEER IN RADIO-PHARMACEUTICALS

So your doctor is going to give you a radioactive drug. Congratulations. It means he is experienced in the practice of some of nuclear medicine's most valuable new skills.

In procedures of this sort, your doctor uses energy stored in the nucleus or inner core of the atom. With its aid, he can study the functions of your body more effectively than ever before. In some cases, too, he may use this same energy to treat disease itself, painlessly and selectively.

This text won't make you a nuclear physician. But it will let you better understand what your doctor is doing. It will help clear up any worries or misunderstandings. And it will give you deserved confidence in radioactive drugs — those important new servants to mankind.

Let's start by looking at the atom. Atoms are the building blocks of all matter. They are the smallest units to which our basic elements (hydrogen, carbon, iron, etc.) may be reduced, and keep their identity. How small? So small you could fit a quarter billion hydrogen atoms side by side into the space of about an inch.

Recently scientists have learned how to change the weight of an atom. They put the material into a reactor. This is a sort of atomic firing range, where the nucleus or heart of the atom is bombarded under high energy. The reactor generally adds atomic particles called neutrons, making the atom heavier. The differing weight versions of the very same element are called isotopes.

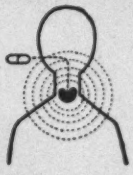
Chemically, all isotopes of an element act exactly alike. But in certain other important ways they may behave quite differently.

For example, some isotopes are radioactive.

These radioisotopes contain excess energy. To get rid of this unbalanced energy, their atoms radiate invisible rays. They are rather like tiny radio or TV transmitting stations, sending out short-range signals.

When you take these radioisotopes in drug form, your doctor can easily trace their passage through your body. It is as if each radioactive atom were broadcasting, "I am phosphorus. I am here in this tissue," or "I am chromium. I am here in these blood cells."

The doctor picks up transmissions from the radioactive drugs in your body, using a sensitive detector. With this help he can measure metabolism, digestion, blood flow, excretion, and other complicated activities.



The doctor's most frequent use for radioactive drugs is in testing the thyroid.

The thyroid gland is your body's speed governor. It regulates your rate of metabolism (that is, the rate at which your cells carry on their activities). It also has other vital functions.

The doctor simply gives you a small, tasteless capsule to swallow at a certain hour. It contains a diagnostic dose of radioactive iodine. Scientists call this special kind of iodine by the symbol, I^{131}.

The thyroid gland has a special attraction for iodine. As you digest the capsule, your blood stream carries I^{131} to the thyroid. The more active your thyroid, the faster it takes up I^{131}.

A few hours later you are ready to be tested. The procedure is perfectly comfortable. It simply requires you to sit or lie for a few moments, while

a detector tube is held several inches away from your throat.

The more active your thyroid, the more I^{131} it now contains. Rays from the I^{131} pass right through your neck. They cannot be seen or felt. But with a detector and counting device, the doctor can quickly measure them. With this information on your degree of thyroid activity, he can calculate your metabolic rate.

When desired, he can obtain other useful information, too, such as the rate that your bloodstream clears away the I^{131}, how well the iodine is converted by your thyroid, how much of it is excreted, etc.

Similarly, your doctor may use radioactive drugs to diagnose other conditions.

For example, he may inject a small amount of radioactive material into the blood stream. Fifteen minutes later he measures radiation from a sample of blood. By noting how far the radioisotope is now diluted, he learns whether or not the patient has the normal amount of blood. He can use the same principle to measure plasma, and to count red blood cells. Or, as the isotope is carried by the blood stream, he may use detectors to follow it; thus he can tell if the blood circulates well, and can locate any trouble spots.

Or he may give the patient a capsule of radioactive vitamin B_{12}. By measuring how much activity is lost with the urine, he can discover vitamin deficiencies such as pernicious anemia.

There are many such tests.

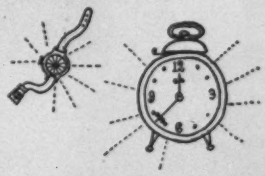
Some radioisotopes can help relieve disease, too.

By using radiations from therapeutic isotopes, the doctor is sometimes able to eliminate certain diseased tissues from the body, leaving healthy tissue unharmed.

Or, if the patient has an enlarged thyroid, his doctor may sometimes use energy from a radioactive drug to remove the excess tissue. The patient simply swallows his medicine, and radiations do the job painlessly and without surgery. Therapeutic radiation can be closely controlled and confined. Thus it is possible for the doctor to treat a thyroid with ultra short range radiations, without affecting the immediately neighboring parathyroid.

Radiations can even give the doctor "before and after" pictures of the thyroid, something like X-ray pictures.

One of the interesting things that contributes toward the safety of radioactive drugs, is how very small a dose is needed. This is particularly true of the diagnostic doses, used for tests. Modern electronic detectors are so remarkably sensitive, that the doctor need give only the tiniest trace to get results.



Indeed, if you were to cut open a capsule of diagnostic I^{131}, you would think it were empty. So little material is used you can't even see it.

Or, let's find an example from your own home. Perhaps you own a wristwatch or an alarm clock with a luminous dial. If you have had it any appreciable length of time, it has emitted far more radioactivity than the average diagnostic dose.

Another safety factor of isotopes suitable for drug purposes, is the short life span of their useful energy. Their radioactivity is used up quickly.

Many such isotopes last but a few days from the moment they are manufactured. For example, phosphorus^{32}, a well-known medical isotope, has a "half life" of two weeks. That is, half its present energy is exhausted in two weeks. I^{131} has a half life of eight days. Gold^{198} has a half life of less than 3 days. Radiation from a given dose grows weaker and weaker with each passing hour.

Compare this with uranium^{235}, the isotope used for driving nuclear submarines, and for powering electric generating plants. It has a half life of about 700 million years.

But the useful life of radioactive drugs is so short that most of them must be rushed to the doctor by air express, and must be given almost immediately.

By now you are beginning to see that isotopes used for medicine are a very different breed from those you've heard about for war.

They cannot explode. They do not give off heat. They do not cause sterility. Their radioactivity is not "catching"; tissue or clothing through which their rays pass does not become radioactive. Their radiations cannot be seen, felt, smelled, or tasted.

There is nothing particularly new about all this, of course. In one form or another, doctors have been using radioisotopes for decades.

But it is only within the past few years that the huge nuclear reactors have been built. They have at last given us a plentiful basic source of isotopes. Thanks to the reactors and to modern pharmaceutical manufacturing techniques, radioactive drugs are now familiar tools of the medical profession.

To be sure, radioactive drugs must always be handled with respect. Like all other potent drugs, they are to be given only under careful supervision, in certain stated ways.

But your doctor has been thoroughly trained in their use. He will attend to the proper precautions, and will tell you of any special cooperation he may need from you. You can do your own part, by following his instructions to the letter.

Under the skilled hands of American doctors, radioactive drugs have rolled up an impressive record of safety and reliability. Every year tens of thousands of new patients are being benefited by them.

And the number steadily increases. You are in good company.

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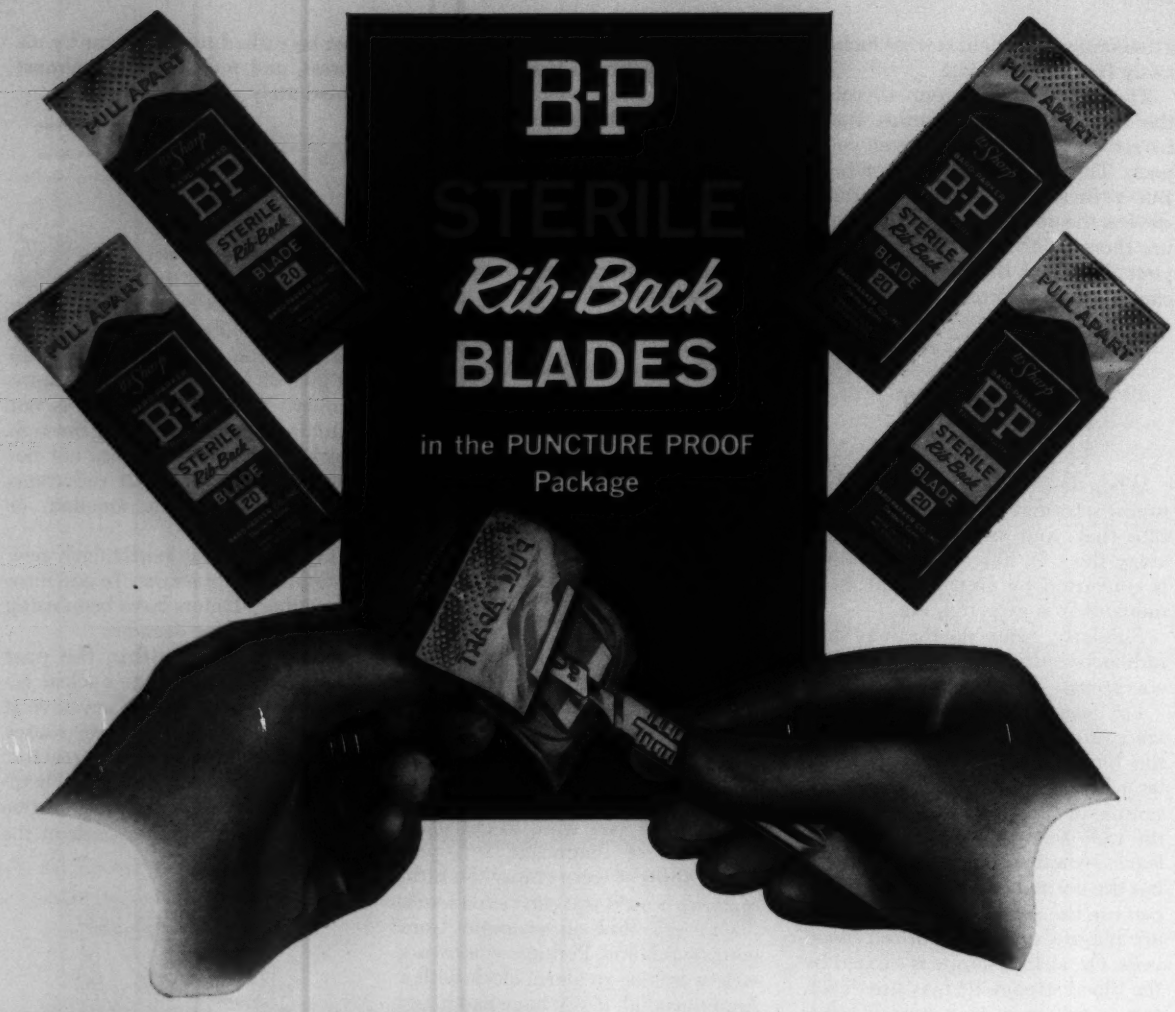

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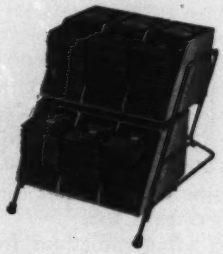

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introducing the authors

Sumner Price, M.D., administrator of Queen's Hospital, Honolulu, Hawaii, outlines the history and variety of hospitals in the newest state-to-be and discusses some of the problems Hawaii's hospital administrators face in his article on p. 50.

DR. PRICE

Dr. Price has completed 16 years of service in Hawaii. In 1943 upon retirement from military service, he was persuaded to accept the medical directorship of Queen's Hospital. He directed the laboratories and medical activities of the hospital for the next six years prior to his appointment as administrator in 1950.

Dr. Price serves as a regent for the American College of Hospital Administrators and American Hospital Association alternate delegate for Hawaii.

His work on the mainland was primarily concerned with pathology. After graduation from the University of Louisville medical school and completion of an internship at Oklahoma State University Hospital, he held teaching positions in pathology in New York.

He is a fellow of the American College of Pathologists.

L. S. Stuart, who discusses the effectiveness of chemical germicides in maintenance of hospital antisepsis in his article on p. 59, is head of the bacteriology section, Pesticides Regulation Branch, Plant Pest Control Division, U.S. Department of Agriculture.

MR. STUART

Thirty years ago Mr. Stuart began his association with the USDA. He has been active in bacteriological and biochemical investigations of food processing, leather tanning, disinfection and sanitation. In 1956 he was recipient of the Superior Service Award given by the Department of Agriculture.

He has also served as an assistant editor of *Chemical Abstracts,* Section 11C, for 17 years.

Mr. Stuart is a member of the American Society of Bacteriologists, American Chemical Society and the Association of Official Agricultural Chemists.

He received his B.S. and M.S. degrees from the University of Maryland.

Lawson A. Morgan, purchasing agent at Mountainside Hospital, Montclair, N.J., describes some of the new pieces of electronic, nuclear-powered and other types of equipment to be used in the hospital and their application for better patient care (p. 83).

Mr. Morgan has been engaged in hospital purchasing for the past 13 years, with 11 years of service at Mountainside Hospital.

Mr. Morgan currently serves as a member of the committee on purchasing, New Jersey Hospital Association, and as president of the North Jersey chapter, American Association of Hospital Purchasing Agents.

MR. MORGAN

He entered the civilian hospital field in 1946 after 23 years of service in the U.S. Navy. One of his major military duties included outfitting a 650-bed hospital ship, the *USS Refuge.*

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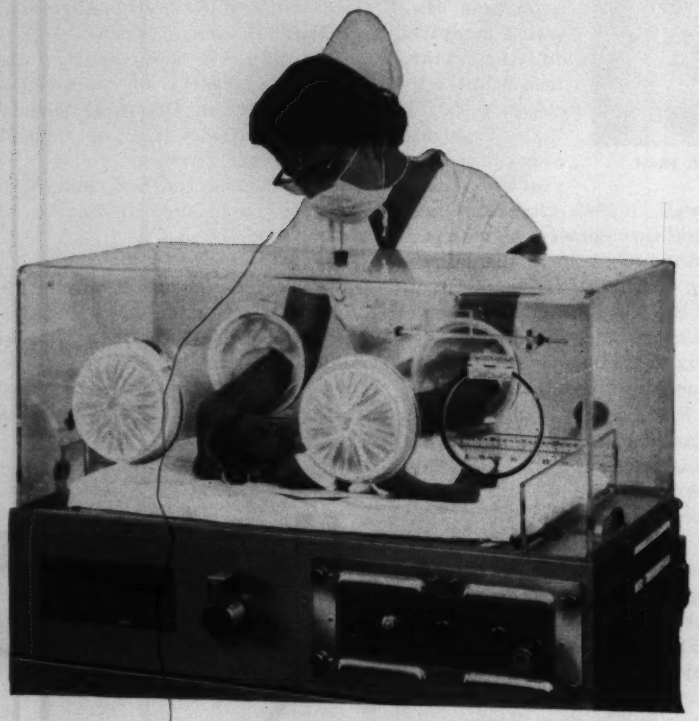

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Temperature control within ±1°F.

Efficient cooling system ensures safe incubator temperatures even when nursery temperature exceeds 95°F.

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For additional information about the *new, model C-77* ISOLETTE, phone us collect (OSborne 5-5200) or write AIR-SHIELDS, INC., Hatboro, Pa. In Canada: 8 Ripley Avenue, Toronto 3, Ont. Roger 6-5444.

*Zinsser, H.: Bacteriology, ed. 11, New York, D. Appleton-Century Company, Inc. 1957, p. 244.

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a comparison of nutrients supplied by Full Liquid Diets

based on whole milk*					based on Sustagen*				
DIET	Calories	Protein Gm.	Fat Gm.	CHO Gm.	DIET	Calories	Protein Gm.	Fat Gm.	CHO Gm.
Milk 1 quart	666	34.2	38.1	47.8	Sustagen powder 2 cups (about 24 fl. oz. beverage)	1170	70	10	200
					Milk ½ pt.	166	8.5	9.5	12.0
Cereal ¼ cup (cooked farina)	33	0.9	0.03	7.3	Cereal ¼ cup (cooked farina)	33	0.9	0.03	7.3
Eggs (2)	154	12.2	11.0	0.6	Eggs (2)	154	12.2	11.0	0.6
Orange juice 1 cup	108	2.0	0.5	27.1	Orange juice 1 cup	108	2.0	0.5	27.1
Tomato juice ½ cup	25	1.2	0.3	5.2	Tomato juice ½ cup	25	1.2	0.3	5.2
Cocoa 1 tblsp.	21	0.6	1.7	3.4	Cocoa 1 tblsp.	21	0.6	1.7	3.4
Sugar 1 tblsp.	48	—	—	12.4	Sugar 1 tblsp.	48	—	—	12.4
Ice cream 1 serving	147	2.8	8.9	14.6	Ice cream 1 serving	147	2.8	8.9	14.6
Consomme 1 serving	34	6.7	—	1.8	Consomme 1 serving	34	6.7	—	1.8
Bouillon 1 serving	26	5.1	—	1.3	Bouillon 1 serving	26	5.1	—	1.3
Butter 1 tblsp.	100	0.1	11.3	0.1	Butter 1 tblsp.	100	0.1	11.3	0.1
TOTAL	1362	6.8	71.83	121.6	TOTAL	2032	1[illegible].1	53.23	285.8

Average Minerals and Vitamins: calcium 1400 mg., phosphorus 1340 mg., iron 9 mg., vitamin A 4990 units, thiamine 0.8 mg., riboflavin 2.25 mg., niacin 3.1 mg., ascorbic acid 150 mg., vitamin D 80 units (or 460 units if enriched milk is used).

Average Minerals and Vitamins: calcium 2640 mg., phosphorus 2050 mg., iron 13.5 mg., vitamin A 5500 units, thiamine 3.8 mg., riboflavin 4.25 mg., niacin 35 mg., ascorbic acid 240 mg., vitamin D 230 units (385 units if enriched milk is used).

*Nutrient values, except those for Sustagen, from Bowes, A. deP., and Church, C. F.: Food Values of Portions Commonly Used, ed. 8, 1956.

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Supplying all known essential nutrients, Sustagen is made from powdered whole milk, non-fat milk solids, calcium caseinate, Dextri-Maltose®* and dextrose, plus vitamins and iron.

Sustagen provides all these nutrients in one 8 oz. glass†

Calories	390
Protein	23.5 Gm.
Fat	3.3 Gm.
Carbohydrate	66.6 Gm.
Vitamins	
Vitamin A	555 units
Vitamin D	55 units
Ascorbic acid	33 mg.
Thiamine hydrochloride	1.1 mg.
Riboflavin	1.1 mg.
Niacinamide	11 mg.
Calcium pantothenate	4.5 mg.
Pyridoxine hydrochloride	0.6 mg.
Folic acid	0.3 mg.
Choline bitartrate	55 mg.
Vitamin B_{12}	0.5 mcg.
Minerals	
Iron (from ferrous sulfate)	1.7 mg.
Calcium	700 mg.
Phosphorus	500 mg.
Sodium	210 mg.
Potassium	770 mg.

†Made with ⅔ cup Sustagen powder (100 Gm.) and ⅔ cup water.

*Maltose-dextrins formula modifier, Mead Johnson.

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Six New York Hospitals Struck; Union Threatens Others

A strike against five New York hospitals was called May 8 by Local 1199 of the Retail Drug Employees Union. The hospitals were Beth Israel, Beth David, Bronx, Mt. Sinai, and Jewish Hospital of Brooklyn. Lenox Hill, another hospital that had been threatened, was struck a day later.

On May 8, the union released a statement that within 48 hours it would strike in five additional hospitals.

The strike was preceded by a conference from 3 p.m. on May 7 until 6:30 the following morning. Present at the conference were president of the boards of the affected hospitals, their legal counsel, New York's Mayor Robert F. Wagner and Leon J. Davis, president of the local union. During that conference the hospitals again confirmed their rejection of the fact-finding committee suggested by Mayor Wagner, and argued for their substitute 10-point program for improving wages and working conditions of hospital employees. The labor union leader refused to accept the hospitals' proposal and left the meeting.

As a result of an order obtained by the hospitals restraining the union from striking, Mr. Davis was summoned to report for a hearing on May 12. The hospitals contended that disregard of the injunction by the union made the strike illegal.

The five hospitals first affected by the strike reported an 80 per cent walk-out in the dietary and housekeeping departments. Three of the hospitals said they also had lost 80 per cent of their aides and orderlies through the strike.

The order restraining Mr. Davis and his union from striking against the hospitals and "endangering lives" had been obtained by the hospitals May 6.

On the previous day, the union and New York Mayor Robert F. Wagner received a statement from a steering committee representative of the voluntary nonprofit hospitals of the city in which the committee turned down the mayor's request that a fact-finding committee review employment conditions in voluntary hospitals. The union had threatened to strike on April 22, and agreed to a two-week strike postponement after the suggestion for a fact-finding committee was made (**HOSPITALS**, J.A.H.A., May 1, p. 17).

In the statement rejecting Mayor Wagner's proposal, the steering committee presented a 10-point program for "the improvement of wages and working conditions of the nonprofessional employees of voluntary nonprofit hospitals of New York City."

Local 1199 turned down the hospitals' program and said a strike would come without notice to the public or the hospitals any time after midnight of May 6. The six hospitals stated that since Mr. Davis would not give a strike deadline, they felt they had to apply for a restraining injunction in the public interest.

The 10-point program suggested by the New York hospitals included adjustments or changes concerning wages, minimum pay rates, working hours, payments for overtime, rate ranges (based on job grades to be established), and fringe employee benefits. The proposal also said that "hospitals will make known to their employees their recognition of the right of any employee to join or remain a member of a union without fear of discrimination."

The steering committee further said each hospital would prepare a list of employees in accordance with their seniority by July 1, and that "layoffs for lack of work shall be made in accordance with seniority . . ." The hospitals also intended to provide grievance and appeal procedures for their employees.

A seven-member permanent administrative committee was set up to supervise the program and to review annually "wage levels and personnel policies then prevailing in each of the voluntary hospitals." After the annual review, the administrative committee would suggest improvements or modifications to the hospitals.

REPORT FROM WASHINGTON—The House Appropriations Committee, led by Rep. John Fogarty (D-R.I.) has recommended $143.7 million for the 1960 Hill-Burton program. This figure is $42.5 higher than the administration's allotment for the program. Subsidies for basic hospital construction represent most of this increase. The committee's proposal for medical research funds increased by $50 million the appropriation requested in the administration's budget. Cancer research, with $83.3 million, accounted for the largest portion of the $344.2 million proposed by the committee for medical research. The House committee also voted for increases over the administration request for (1) construction of research facilities, (2) Public Health Service hospitals, and

Worth Quoting

"As a . . . working principle . . . it might be well to remember that it is better to leave a question unsettled *after* debate, than to settle it *without* debate."—Dr. Leroy E. Burney, *surgeon general, Public Health Service, at the PHS-American Hospital Association Regional Conference on Development of Principles for Planning the Future Hospital System, Chicago, April 15, 1959.*

(3) Indian health. Details p. 111.

Two congressional committees in April heard testimony from the American Hospital Association and other groups on low interest hospital construction loans and federal employees health insurance.

Dr. Robin C. Buerki, chairman of the AHA Council on Government Relations, presented the Association's views on hospital construction loans, pointing out that many hospitals cannot obtain commercial loans.

J. Douglas Colman, vice president of the Blue Cross Association, gave support to a Senate bill concerning health insurance for federal employees. He said, however, that certain changes in the bill were necessary to "improve its consistency and clarity." Details p. 113.

COMPULSORY ARBITRATION BILL DEFEATED IN CALIFORNIA—A bill which would have provided for collective bargaining between hospitals or institutions and their employees has been defeated in the California Assembly (lower house). The bill also proposed that if the employers and employees could not agree upon a contract, there would be compulsory arbitration to establish the contract.

Provisions of the bill, which was intended as an addition to the California Labor Code, excluded state, county or city hospitals and institutions; they included proprietary and nonprofit hospitals and district hospitals. The bill had been approved by AFL-CIO as part of its official legislative program. It had been vigorously opposed by the council on legislation of the California Hospital Association.

NAPNE SUPPORTS JOINT ACCREDITING SERVICE WITH AHA—The National Association for Practical Nurse Education held its 18th annual convention in Cincinnati April 27-May 1. Resolutions approved at the convention stressed the importance of NAPNE in the guidance and encouragement of practical nurse education, with particular emphasis on the accreditation of schools of practical nursing.

The association stated that NAPNE members at the convention supported the development of a joint accrediting service with the AHA, but resolutions voiced strong opposition to duplication of accrediting services by the National League for Nursing.

Eleanor Gaffney, R.N., director of nurses and principal of the Tewksbury Hospital School of Practical Nursing, Tewksbury, Mass., was elected the new president of NAPNE.

TRI-STATE ASSEMBLY MEETS IN CHICAGO—Speakers at the Tri-State Hospital Assembly in Chicago April 27-29 stressed the importance of hospitals as community health centers, the continuing rise in hospital costs, and the increasing interest on the part of the public and the labor unions in hospital operation. Physicians, hospitals, insurance companies, and the general public came under criticism as contributing to the over-use of hospitals. The assembly was also warned about legislative actions that might bring about controls of hospital operations. Details p. 116.

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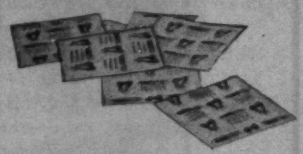

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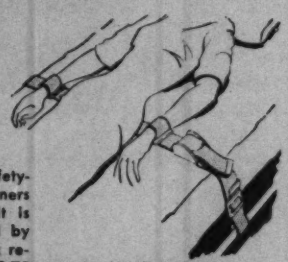

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Here's furniture that puts new cheer and friendliness into any patient room! New Simmons Vivant cabinets and chests glow with the warmth of wood-grained Fiberesin phenolic laminate—beautiful to the sight and to the touch. Gracefully simple in design, Vivant has a fresh, modern look that will wear well for years to come. All Simmons hospital beds can be Vivant-paneled —and, to complete the effect, there is a new Simmons high-backed hospital chair with an ottoman.

Light-hearted in looks, Vivant is carefree in maintenance. Fiberesin tops, fronts and sides are immune to scratching, bumps or knocks...can't be discolored by wet objects or marred by cigarettes. All welded steel construction won't warp or sag. Let Vivant add new attractiveness to your patient rooms...the price is surprisingly modest!

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Amplification on mail rates

Does last year's postal rate increase legislation continue to provide entitlement to preferred rates on second and third class mail to nonprofit hospitals?

Last year's postal rate increase legislation does entitle nonprofit hospitals to preferred rates on second and third class mail.

Application for entitlement to such preferred rates must be made to the local postmaster. If he declines to provide such applications, appeal may be taken to the Postmaster General. If, in the past, your hospital has been entitled to use preferred rates by virtue of the approval of your application by the local postmaster, it should be unnecessary for you to reapply.

As you may know, the rate on bulk matter, if mailed by the pound, was increased, effective January 1, 1959, from 14 cents to 16 cents a pound. There is no exemption for anyone from this increase. Also effective that date, the rates prescribed by last year's legislation for all third class mailings, other than the minimum, will apply to all users, including charitable organizations. The minimum established by the law was 2 cents per piece, if mailed in bulk.

Nonprofit hospitals, however, have been entitled to a preferred rate of 1 cent per piece or 50 per cent of the minimum. The rate increase of 1 cent per piece did not affect nonprofit hospitals establishing the right to use the preferred rate.

After July 1, 1960, this minimum per piece rate increases to 2½ cents. Hence, since nonprofit hospitals have a right to a 50 per cent preference on the minimum charge, they will only have to pay 1¼ cent per piece mailed in bulk or a ¼ cent increase over the current rate.—JOHN T. KELLY

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

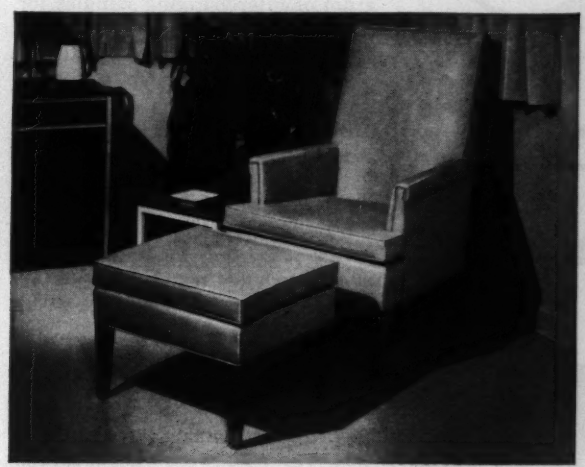
Ceramic tile walls

We have ceramic tile walls in the operating suites in our hospital. Do you feel there is any possibility of infection being spread by the grout between ceramic tile?

This question was referred to J. C. Colbeck, M.B.B.S., special consultant to the Association's Committee on Infections. His answer is as follows:

Once the wall is installed, I do not think there is any appreciable danger from this source. Naturally, as smooth a wall as possible, which enables ready cleaning, is the ideal but I do not think that walls are a cause for surgical infection.

There have, however, been re-



Every detail contributing to patient comfort is built into this new Simmons hospital chair (UF-7200-F) and ottoman (UF-7202-F). The chair back is high to provide restful head support. The helical-suspended seat tilts to the correct posture-angle for persons of any weight. Seat cushioning consists of famous Beautyrest® independently pocketed springs—proof against sagging—and foam rubber top cushions. Doe-Vin Naugahyde upholstery.

Utility becomes beautiful in this new Vivant hospital bedside cabinet (F-16340-115) by Simmons. Its top, front and sides are sheathed in Fiberesin—the "peopleproof" wood-grained phenolic laminate. Rough treatment cannot hurt this surface—can't dent, split or abrade. Even fruit acids, grease, alcohol, fingernail polish or forgotten cigarettes cannot damage it. Side chair (FC-786-303) has upholstered seat and back in Doe-Vin Naugahyde.

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ports of infections due to clostridium group of bacteria which includes tetanus and gas gangrene organisms when there has been atmospheric pollution of the operating room suites during the course of operations owing apparently, to the infection of plaster, etc., by these organisms (during repairs and alterations).

In brief, I think that the only time that the grout between the wall tiles might be a danger is at the time when they are being put up or torn down. The only matter worth consideration is to produce a wall which is as easily cleaned as possible.—J. C. COLBECK, M.B.B.S., *chief of service pathology, Shaughnessy Hospital, Vancouver, B.C.*

Caster marks on floors

Certain casters leave marks on our hospital's new vinyl plastic floors. Can you give us any information on how to correct this?

Caster marks on certain types of flooring, such as vinyl plastic, are the result of a chemical reaction between the compounds in the caster treads and the compounds in the flooring material.

It is possible to avoid this staining by the use of compatible materials in the tread and floor coverings. Consultation with manufacturers of these items, will lead to the proper selection of casters and, thus, reduce the problem of stains.

New hospitals, hospitals under construction, or those planning additions which will utilize this type of flooring are particularly cautioned to consult the caster manufacturer before ordering any equipment using casters.

A more difficult problem is created when old equipment is utilized on a new floor of this type. It may be necessary to replace the casters on the old equipment with some that are compatible with the type of flooring. This problem, however, should be considered before selecting a new flooring material.

The manufacturers of both flooring and casters are aware of this situation and have initiated a program of interchanging samples for compatibility testing. The Caster and Floor Truck Manufacturers Association has set up a special Floor Tile-Caster Compatibility Test Committee to make a careful study of this problem.

—JACK D. DILLMAN

Use of AHA seal

Is it permissible for American Hospital Association members to use the AHA seal on any employee service pin?

It is perfectly proper for member hospitals of the American Hospital Association to make use of the middle portion of the AHA seal. The AHA does offer a service pin, however, this was done for convenience to members who did not wish to invest in the additional cost of separately designed pins.

The Association requires that member hospitals, using the seal of the AHA, execute a seal agreement, indicating the use of the seal. The most common use, of course, is on the hospital letterhead. Some hospitals use it on a wall plaque or, as you indicated, on service pins.—JOHN E. SULLIVAN

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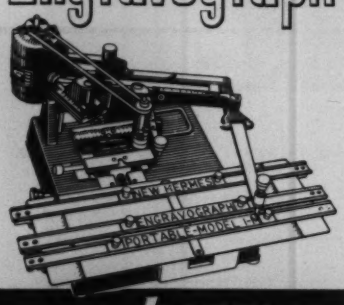

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opinions and ideas

LETTERS TO THE EDITOR

Plastic mattress covers

Dear Sir:

Reference is made to an article on plastic mattress covers by Mr. G. A. Weidemier that appeared in the "Service from Headquarters" section of the January 1 issue of HOSPITALS, J.A.H.A.

It is believed that because of the omission of certain information concerning oxygen tents and static electricity that this article could be misleading to persons having the responsibility of administering oxygen to patients. It is because of this that I would like to present some additional comments on the general subject.

An excellent source of information is available on this subject in the contents of the National Fire Protection Association Bulletin No. 56, *Safe Practice for Hospital Operating Rooms*, and NFPA Bulletin No. 565, *Nonflammable Medical Gas Systems.*

The use of plastic mattress covers on beds where oxygen is administered by tent must be considered a potential hazard. An acceptable substitute for plastic mattress covers is conductive rubber sheeting. The same or equivalent material should be used for the covering of all operating tables and stretcher pads, pillows and cushions used in the operating room. It is suggested that the conductive rubber sheeting be tied in to the metal portions of the bed as a means of equalizing electrostatic charges and to reduce or eliminate one possible source of ignition.

A review of several oxygen tent fires, some of which resulted in fatalities, revealed that static electricity was a contributing factor. As plastic materials are readily charged with static electricity, we can eliminate one very obvious source by prohibiting the use of plastic mattress covers in oxygen tents. It has been indicated that the use of flammable solutions as a rubbing medium, alcohol swabs and methane gas, a product of digestion, could be fuel for a fire if static sparks were present. It is, therefore, recommended that only aqueous solutions be used as a rubbing medium in oxygen tents.

It is further recommended that the use of wool blankets and nylon fabrics be prohibited in oxygen tents. Silk and most synthetic materials present the same potential hazard as wool and nylon. Voltages causing static sparks can be built up by the movement of a patient on such materials. Drawing a sheet across a plastic mattress cover will produce very high voltages. It should be stressed that while oxygen by itself will not burn, when associated with a highly combustible material and sufficient heat will aid violent combustion or explosion.

Since the HOSPITALS article generally refers to a room where oxygen is being used, it is believed that the additional information concerning oxygen tents and static electricity would tend to preclude the possibility of creating any additional hazards with oxygen therapy.—ELMER C. MAHER, *area safety and fire protection engineer, Veterans Administration, San Francisco.*

* * *

Dear Sir:

With reference to the item about plastic mattress covers and oxygen tents . . . I think it should be pointed out that this question is still annoyingly controversial.

There has been some experimental work done on it at Underwriters' Laboratories, at St. Francis Hospital, Pittsburgh, and at the Bureau of Mines. The Underwriters' Laboratories were able to ignite cotton fabrics in a highly enriched oxygen atmosphere by static sparks at a potential of 11 kv and an energy of 0.07 joule. This was provided from a condenser with a capacity of 1160 MuMuF. This is an energy and a capacity at least of the order of

magnitude which can be generated by personnel working around a patient. The Pittsburgh group experimented directly on oxygen tents as subject and found that in practice they could produce maximum energies of about 5000 volts on mattress covers but could not ignite them with static sparks of up to 78,000 volts and adequate capacity.

These two results are not contradictory; they simply demonstrate, at least in my view, the difficulty in practice of developing very high oxygen concentrations in an oxygen tent.

Dr. Thomas of the St. Francis Hospital will publish a more detailed description of these observations in the near future.

As a member of the National Fire Protection Association Committee on Hospital Operating Rooms, I think that it is a fair expression of the general attitude and belief of the committee that the use of plastic canopies on the oxygen tent and plastic mattress covers will present a relatively minor hazard. I know that the committee is unanimously convinced that the major hazards are the use of flammable body rubs and hair oils in the presence of oxygen concentrations which are produced in oxygen tents and that hospital personnel should be carefully trained in the avoidance of these materials and of major sources of ignition such as matches and smoking materials in any room where oxygen is being administered.—F. A. VAN ATTA, *industrial hygienist, Industrial Health and Safety Division, United Auto Workers.*

Purchasing guide fills need

Dear Sir:

Congratulations on the addition of the "American Hospital Association Purchasing Guide" that appeared on pages 87 and 89 of the Feb. 16, 1959, issue of the Journal.

This is something I have begged for, and I sincerely believe it will be of great service to all of our membership. Thanks a million for making it available in appropriate form so that it can be easily removed for filing purposes.—W. S. MURPHY, *administrator, Good Samaritan Hospital, Lexington, Ky.*

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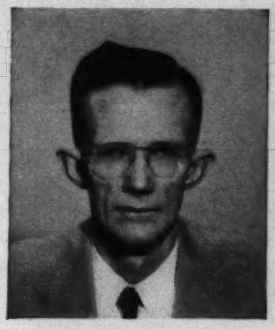

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References: 1. Pratt, J. H. and Jackman, R. J., Proc. Staff Meeting, Mayo Clinic, 20:277, 1945. 2. "Injuries to bowel as result of an enema", Finch, H. C. and Lanier, L. R., Jr., Am. Jl. Obst. & Gyn. 74:146, 1957. 3. Bookmiller, R. N. and Bowen, O. L., "Textbook of Obst. and Obst. Nursing", 3rd Ed., Saunders, 1958.

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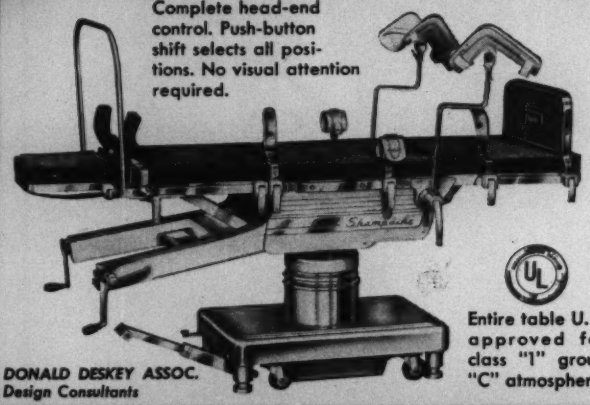

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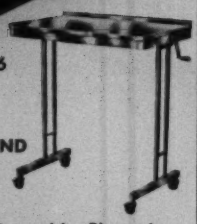

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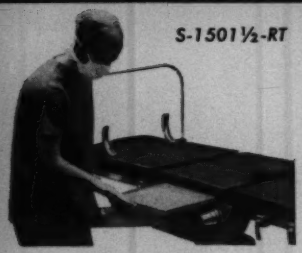

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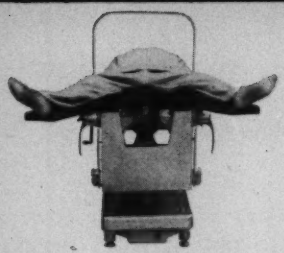

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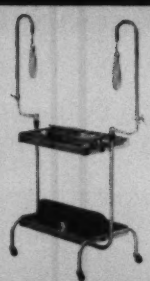

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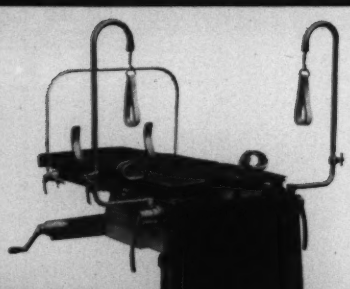

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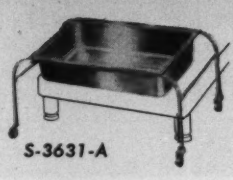

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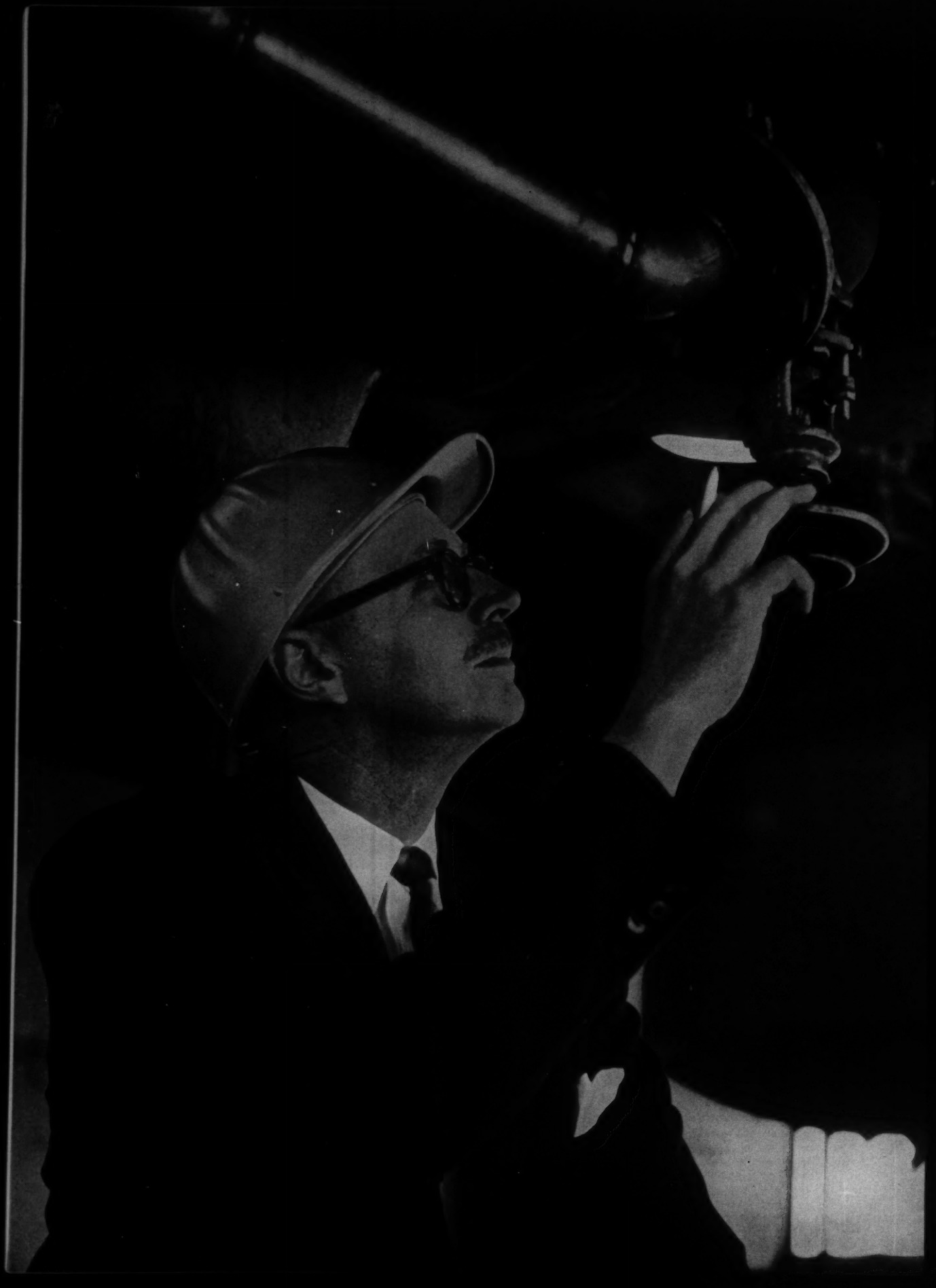

Vessels for mental health

To make phenothiazine ataraxics, modern pharmaceutical production requires gigantic and complex equipment. The camera shows some of it here at Wyeth's Fine Chemicals Section in West Chester, Pa. Standing in stainless-steel platoons two and three stories high, weighing many tons, its target is the tiny hypothalamus, weighing about 4 grams.

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As manager of the Fine Chemicals Section of Wyeth, Dr. McCoy is a rare example of the expert's expert. His is a field requiring one of the highest human skills, coaxing the right reactions from massive vessels. He sets up the step-by-step techniques. He writes the operating data that guide his supervisory chemists and operators through the entire intricate process. His instructions include the selection of apparatus, the choice of reagents, the time, temperature, and pressure needed for reaction, the purification and recovery of the drug.

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Dr. McCoy and his group are part of the notable team that Wyeth has assembled for service to medicine. Their skill and dedication aid the hand that writes prescriptions.

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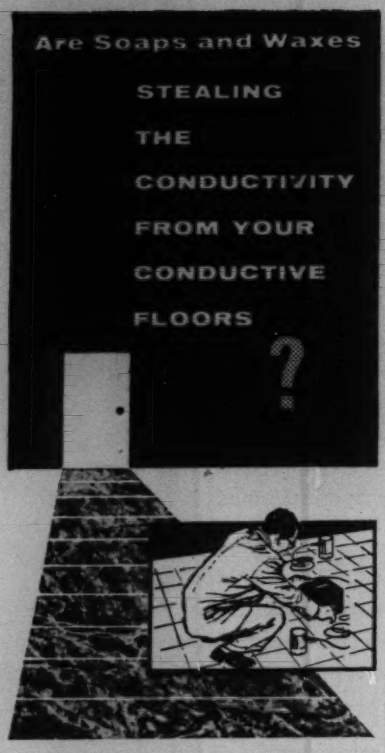

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accreditation problems

KENNETH B. BABCOCK, M.D.

- governing board-medical staff conflict on accreditation
- loss of accreditation and approval of educational programs
- efficacy of newborn footprints evaluated

Suppose a governing board desires accreditation and the medical staff does not. What is the next step?

Accreditation should be considered as one, tangible, documented measure of the overall picture of better hospital patient care. Presented in that way, no medical staff can affirm that they are against "better care". Without being arbitrary or demanding, the governing board might pursue the following program:

1. Find out why the medical staff does not want accreditation, getting specifics as much as possible.
2. Initiate an educational program on the value of accreditation to the community, the hospital and medical staff.
3. Get one or two key personnel on the medical staff interested and work through them.
4. Enlist the support of your hospital auxiliary—its influence can be great.

Is it true that if a hospital loses its accreditation it automatically loses approval of its educational programs by the Council on Medical Education and Hospitals of the American Medical Association?

NO. It is not true and there are many examples to prove it. As a hypothetical case, we might nonaccredit a hospital because of a bad fire hazard. They do have a top-notch educational program and this fire hazard, although not condoned, should not eliminate a good educational program. The Council on Medical Education and Hospitals has said that in its opinion a *new* hospital or a hospital applying for a new educational program should first be accredited by the Joint Commission on Accreditation of Hospitals, but an already approved internship or residency is not automatically nonapproved on the basis of nonaccreditation by the Joint Commission on Accreditation of Hospitals.

Some of our staff have questioned the value and efficacy of footprints on newborn infants. Does the Joint Commission require them and are they actually of value?

The Joint Commission does not require footprints per se as identification of babies. Frankly, good footprints can be of great value and they can be absolutely worthless, if smeared or taken carelessly. It is best for the administrator to check with local and state boards of health and find out their requirements and suggestions. Next, it would be well for the administrator to ask the local police or sheriff's department to give the obstetrical nurses a demonstration of proper techniques and then to follow them on infant identification.

The Joint Commission wishes to help all hospitals exercise the "due care" required by law. The Commission's interpretation of this "due care" would be at least one identification on every baby, of two separate categories. JCAH surveyors are asked to check: (1) identification by means of a bracelet, necklace, dog tag or adhesive tape; (2) identification by means of footprint, palm print or fingerprint. At least one means of identification in each one of the two categories is a must. If a baby leaves the hospital, the latter category remains the best legal identification of the child in loss due to being stolen or abandoned, or in a claim of mixed or wrong babies.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 660 N. Rush St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

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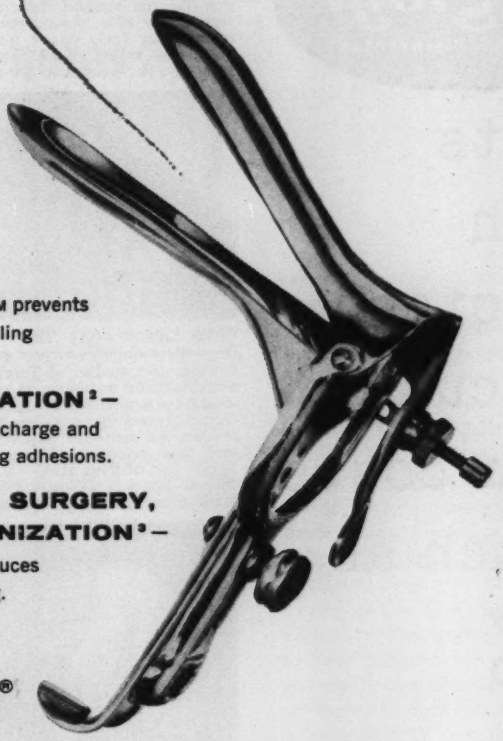

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Time studies under actual hospital conditions *

Cuts labor cost 47%
(by mop-and-pail method)

Comparative time studies of Tergisyl vs. conventional method of washing and disinfecting using mop-and-pail technics reveal that one-step Tergisyl method reduces the man-time required by 47%. Actual time saved was 25 minutes per 1,000 square feet of floor area — a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.

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* *Details available on request.*

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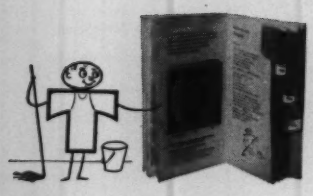

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—two milestones for Hawaii

THE YEAR 1959 marks the year of Hawaii's statehood and the centennial of her first hospital, the Queen's Hospital, founded to care for native victims of scourges brought by travelers from the outside world. Since then, Hawaii's hospitals have played an important part in the transition of the islands from a polluted paradise to a healthy state.

The statehood saga began almost 200 years ago when the adventurous Captain Cook and the colorful trading ships that followed him to the Pacific brought back the news of the discovery of a chain of beautiful islands whose natives excelled in the creation of intricate feather-works; these men of all lands brought to the islands all the ugly diseases to which the natives had developed no immunity.

The sailors and the governments that followed them had no provisions for the care of the natives they had infected. The Queen's Hospital was founded in 1859 to care for what was left of the plague-decimated native population.

In an article starting on page 50, Sumner Price, M.D., administrator of the Queen's Hospital, discusses the extraordinary progress that has been made in the public health of the islands since the hospital he administers was founded 100 years ago. The thatched huts for the ill have been replaced by more than 6000 hospital beds; the smallpox which threatened to annihilate the people in 1853 has not reappeared in 46 years.

In this year of Hawaii's admittance to the Union and the centennial of her first hospital, the American Hospital Association welcomes all Hawaiian hospitals and all who work for them in the Aloha state.

—updating the admittance form

COMPLETING THE admission form is an annoyance for most incoming patients and a tiresome—although necessary—detail for admitting clerks. Hospitals frequently are criticized for admission delays and certainly the paper work connected with admissions should be minimized. In this era of liability suits, however, an explanation of the conditions of admission cannot be eliminated without serious legal consequences.

Often, the most voluble complaints about alleged red tape surrounding a hospital admission comes from patients who are disposed to file suit against the hospital. A recent psychological study that delved into the personalities of individuals involved in malpractice litigation bears this out. The study indicated that persons who sue doctors and hospitals frequently have a history of complaints behind them.

The increasing number of legal actions taken against hospitals has forced many institutions to critically examine all procedures, from admittance to discharge. Such an examination is a healthy step. It can and usually does result in improved service. In the past, for example, the admittance form has often been "outdated and treated as a stepchild," as James E. Ludlam points out elsewhere in this issue.

Such an approach to the admittance form is unfortunate and unnecessary. An admittance procedure cannot be considered truly modern without an up-to-date admittance form. The California Hospital Association recently sponsored a project designed to produce such a form. The resultant form has been revised several times and is now in use in many California hospitals. The details of the form, and the thinking behind it, are described in an article by Mr. Ludlam starting on page 43.

PART ONE OF A TWO-PART ARTICLE

CONCEPTS OF PROGRESSIVE PATIENT

by JACK C. HALDEMAN, M.D., and FAYE G. ABDELLAH, R.N.

I. WHAT IS PROGRESSIVE PATIENT CARE?

The central theme of the progressive patient care concept is the organization of facilities, services, and staff around the medical and nursing needs of the patient. Its objective is that of tailoring services to the needs of the individual patient—whether in the hospital or the home. Patients are grouped according to their degree of illness and their need for care. The staff serving each group of patients is selected and trained, and the facilities are organized, to provide the kind of services needed by that group.

This concept has been applied to postoperative surgical patients for many years by grouping them in the recovery room where they are cared for by specially trained staff. The intensive care units now being established in many hospitals represent an extension of the recovery room idea to include acutely ill medical as well as postoperative patients, and to care for them as long as they are critically ill. Segregation of ambulatory patients into self care units is a logical extension of the concept to meet the needs of patients at the other end of the scale.

Removal of intensive and self care patients from the general nursing unit leaves two groups of patients, those who may be classed as "intermediate", and those who will need care of relatively long duration. Some of the latter group can, if the needed hospital services are extended to the home, leave the hospital. On the other hand, in most communities there are many persons whose care, treatment, or rehabilitation could be improved by bringing them into the hospital if a suitable long-term care unit were available. Establishment of a long-term care unit in the general hospital may, therefore, not only relieve the pressure on acute general beds but also provide more suitable care for patients who otherwise would be occupying such beds, or would be at home.

To make the specialized services of the hospital available to patients in their homes requires organization in relation to community services and agencies outside the hospital. Indeed, a home care program may or may not be hospital based, but if it is designed to provide needed services to patients best cared for at home, it comes within the concept of progressive patient care.

Although this paper is concerned primarily with the application of the progressive patient care concept to the general hospital, it is emphasized that the concept is applicable to any organized means of providing health care as long as the focus is on the needs of the individual patient in the community in which he resides. The current trend in the care of the nation's mentally ill is an example of such application. An ever increasing proportion of these patients is being hospitalized in community hospitals rather than

In Part I of a two-part article the authors examine the concept of progressive patient care and outline the characteristics of the five elements of progressive patient care as organized in a general hospital; the intensive care unit, the intermediate care unit, the self care unit, the long-term care unit and the home care program.*

In the second part of this paper, scheduled to appear in the next issue of this Journal, the authors will discuss some of the unanswered questions on progressive patient care and outline the considerations to be kept in mind in planning the introduction of a progressive patient care program.

Jack C. Haldeman, M.D., M.P.H., is assistant surgeon general and chief, Division of Hospital and Medical Facilities, Bureau of Medical Services, U.S. Public Health Service. Faye G. Abdellah, R.N., Ed.D., is project director, Nursing Research Studies on Progressive Patient Care, Division of Hospital and Medical Facilities, Bureau of Medical Services, U.S. Public Health Service.

*Further elaboration of the authors' current thinking regarding application of the progressive patient care concept is contained in the publication, "Elements of Progressive Patient Care", which is in press and may be obtained from the U. S. Public Health Service.

'Progressive patient care . . . shows promise of helping hospitals with their two most pressing problems: scarcity of trained personnel, and continuing improvement of services without unduly increasing costs.'

CARE

in large mental institutions, and followed up in specialty clinics or in outpatient departments. Even when a patient has been institutionalized, current practice frequently provides for his gradual reintroduction into the community through living-in arrangements, halfway houses, and follow-up.

Organized home care programs, as an extension of hospital services or health department activities, reduce the need for patients to be hospitalized. Such a pattern of organization of care for the mentally ill will make us far less dependent on the large state mental institutions and more dependent on community facilities and programs which bring services to the mentally ill at the community level where many of the needed services can be most effectively provided.

Returning to the general hospital, the above discussion leads us to visualize five types of units: intensive care, for the seriously or critically ill; intermediate care, for the patient requiring a moderate amount of care; self care, for the physically self-sufficient; long-term care, for those needing hospital services over a prolonged period; and home care. Although the last unit serves patients not on the hospital census it needs to be an integral part of the program if the hospital is to realize its full potential as a community health resource. These units will be discussed in greater detail below.

II. WHY PROGRESSIVE PATIENT CARE?

Hospital management is always on the lookout for more effective ways of achieving the objective of maximum service and the lowest cost consistent with high quality care. Progressive patient care is a different way of organizing the services of the hospital. It shows promise of helping hospitals with their two most pressing problems: scarcity of trained personnel, and continuing improvement of services without unduly increasing costs.

The medical profession and the American public expect and demand increased and better hospital services; at the same time much concern is being expressed regarding the ever-rising costs of hospital care. Related to these problems is the need for more trained personnel than are available.

The public has become increasingly aware of the advantage of hospitals and nursing homes for the treatment of illness. Physicians require the hospital's resources to apply modern techniques of effective diagnosis and therapy. Each year a larger percentage of our population is over 65 years of age and persons in this age group require twice as much hospital care as younger persons. Some illnesses and injuries, formerly quickly fatal, now are effectively treated, but at the expense of many days in the hospital. Further, it can be anticipated that as better methods of financing are found there will be a further increase in use of hospitals by people who do not now use them because of economic barriers.

Some of the very factors which increase the use of hospitals also increase costs per hospital day. The advances in scientific medicine increase comfort and save lives, but more people, space, and equipment are required to do the job. Illness occurs on a seven-day week, but hospital employees are gradually achieving the five-day workweek and the need for greater skills, plus competition for scarce personnel, has forced salaries up. An increase since 1946 of general hospital personnel from 1.5 to 2.0 employees per patient, coupled with salary increases, makes higher per diem costs inevitable.

Thus, hospital administrators are faced with having to provide more hospital days at higher costs per day and with a need for more specialized personnel who are in short supply.

Some comfort can be taken from factors which tend to offset these trends. Some medical discoveries —and hopefully more in the future —eliminate the need for hospitalization for some illnesses. Others have helped shorten the average hospital stay. Improvement in managerial efficiency is another factor.

Since it is clear that hospital costs and needs for scarce personnel cannot be reduced by arbitrarily cutting back services, it is essential to review hospital operations critically. More than this, we need to look at the relationship of the hospital to community health services to see if the balance between inpatient care, ambulatory care, and care in long-term facilities can be adjusted to provide more efficient service.

The progressive patient care concept envisions the general hospital of the future as the focus of both outpatient and inpatient care; as much concerned with care of the long-term patient as with the treatment of the short-term patient; as readily available for as-

'The value of the intensive care unit is enhanced both to the patient and to the physician if arrangements are made to permit direct admission of emergency patients to the unit.'

sisting the physician with care of his patient in the home as for assisting him with care of the patient in the hospital.

Full application of the concept, therefore, involves not only internal reorganization of hospital patient care services, but also evaluation and coordination of the complex of community health services of which the hospital is an important part.

III. PROGRESSIVE PATIENT CARE IN OPERATION

Before considering the specific problems and organizational steps in establishing a progressive patient care program, let us look briefly at the five elements of progressive patient care as they might be applied in a moderate sized general hospital. In a specific situation details would, of course, be modified to suit local conditions and practices. Not all elements need be incorporated in a given hospital; indeed, at the present time few hospitals have all five types. However, as indicated above, we believe that development of the full range of progressive patient care elements is a desirable objective.

Our current thinking regarding these elements has developed from observation and study of the operation of one or more of the elements at a number of hospitals. Particular credit is due to the Manchester Memorial Hospital, Manchester, Conn., where we have done our most intensive studies, for the interest and cooperation of the entire staff in furthering these studies.

INTENSIVE CARE UNIT

The function of this unit is to concentrate in one service area those patients who are critically, or seriously ill, and who require and will benefit from a large amount of highly skilled nursing care and close and frequent, if not constant, nursing observation. Such patients include, for example, major surgical cases following release from the recovery room, multiple injury or burn cases, major or threatened gastrointestinal hemorrhage, acute coronary occlusion, pneumonia, acute thrombophlebitis with danger of pulmonary embolus, etc. Pediatric or psychiatric patients may also be cared for on this unit.

It is evident from the above examples that patients on this unit will require frequent observation of vital signs, measurement and recording of fluid intake and output, close and skilled observation for signs of pain, shock, hemorrhage, respiratory difficulty, increased intracranial pressure, tension pneumothorax, etc. Most of them will be receiving complicated and time consuming treatments. It is therefore necessary to staff the unit accordingly, keeping in mind that in the conventional hospital many of these patients would require special duty nurses.

Personnel for this unit should be carefully selected for their technical skill in handling complicated equipment and in carrying out procedures; ability to make accurate observations on the patient's condition and to interpret these correctly in terms of the need to notify the physician or to institute an emergency procedure; ability to work effectively under pressure in emergency situations; and for the type of personality which is not bothered or rendered insensitive by caring for a continuing succession of seriously ill patients. Since patients are grouped on this unit regardless of diagnosis, the nurse must be well prepared with respect to the special care of a wide variety of postoperative patients, as well as medical, pediatric, and psychiatric nursing problems presented by patients. This may require supplementary instruction to familiarize the nursing staff with special signs to look for in caring for the unusual types of patients, and with new or highly specialized procedures or equipment to be used on the unit.

The staffing pattern will depend on the type of patients being cared for. A unit taking care of patients who have had open-heart surgery may require one nurse per patient per shift, whereas one professional nurse and one practical nurse or nursing aide per unit of five or six patients, per shift, might be sufficient in a hospital without highly specialized services. In considering the level of staffing required, it should be borne in mind that patients do not need their own special duty nurses on the intensive care unit.

It is believed that six intensive care patients are as many as can be kept under adequate observation and care by a single nursing team. Although a number smaller than six may be less economical from the staffing standpoint, adaptation of existing space may require the use, for example, of four-bed rooms. Even in a four-bed room, however, it is possible to utilize the nursing staff more effectively.

Important features of the intensive care unit are the following: elevated, centrally located nurse's desk to facilitate observation of patients; space in the unit for carts for medications, sterile trays, linen, and other supplies; one or two beds closed off by glazed partitions to provide quiet for selected patients yet permit visual observational provision at each bedside of piped oxygen and suction, extra electrical outlets, and blood pressure apparatus.

The value of the intensive care unit is enhanced both to the patient and to the physician if arrangements are made to permit direct admission of emergency patients to the unit. The physician may thus call the head nurse of the unit without going through the admitting office, be assured that a bed is available, give emergency orders, and know that things will

be in readiness for the patient on arrival.

Effective use of the intensive care unit requires that at least one bed be available at all times, especially at night, for emergencies; at the same time it is important to maintain a high occupancy level in the unit as a whole, in order to make full use of the staff of the unit. A method of accomplishing these objectives is to provide a number of beds on the unit for patients who are less critically ill than those in the six-bed intensive care room, but who are still not ready for transfer to intermediate care.

It is important that the medical condition and nursing needs of each patient be reviewed daily by the head nurse and physician so that the patient may be transferred from the unit as soon as his needs can be met elsewhere. Further discussion of this procedure is included in a later section.

INTERMEDIATE CARE UNIT

The intermediate care unit is designed and staffed to care for patients whose care requirements are not such as to call for intensive care, but who are unable to qualify for the self care unit. For example, the moderately ill patient with pneumonia or acute cholecystitis, the uncomplicated postoperative appendectomy, hernia, or pelvic repair, and the partially recovered patient transferred from intensive care, will be appropriate for this unit. Many of these patients will be ambulatory for short periods. This unit may also best take care of patients for whom the prognosis indicates that treatment can be only palliative. It may be expected that a large proportion of hospital patients will be admitted to and discharged from intermediate care. Children requiring care at the intermediate level may be placed on the pediatric nursing unit.

The services provided are similar to those on a general medical or surgical nursing unit, except that most of the emergency and more specialized care services will be done on intensive care. Many patients will have bathroom privileges and most are able to plan with the nurse for their own care and to participate in it. The nurse may need to teach the patient the techniques of ambulation following surgery or a long stay in bed, and to help him accept any limitations produced by his illness. Patients about to be discharged home may need instructions for living at home.

Encouragement and supervision of the activity of the convalescent patient are important aspects of nursing care in this unit. Teaching of good health practices is equally important.

This unit requires a nursing staff similar to that on the usual general medical or surgical floor. Emphasis needs to be placed on teaching the patient about his illness and on motivating him to get well.

The unit will have neither the critically ill patients nor the self care patients found in the conventional hospital nursing unit. There has been insufficient experience to date to indicate how these factors will influence the total nursing personnel requirements for an intermediate care unit.

The size, architectural design, and equipment of the intermediate care unit can, in general, be patterned after the conventional hospital nursing unit.

SELF CARE UNIT

Patients admitted to this unit include those who, although ambulant and physically self-sufficient, require diagnostic study not feasible on an outpatient or office basis; daily or more frequent specialized treatment such as radiation or physical therapy; or convalescent care following acute medical or surgical episodes. A patient may be admitted from his home to the self care unit for diagnostic study, definitive treatment, or preparation for surgery, or he may be transferred to this unit from elsewhere in the hospital when his condition permits. Whether a patient on intermediate care is discharged home or is transferred to self care for a few more hospital days may depend in part on the home situation and the distance and ease of transportation between the home and hospital.

Examples include: the partially regulated diabetic who requires precise dietary management, frequent laboratory tests, and adjustment of insulin dosage, as well as instruction on diet and self-administration of insulin; the postcoronary patient who must learn, under close supervision, how much activity he can tolerate and how to select his diet; the convalescent rectal carcinoma patient who needs a few more days help in bowel training and colostomy management; the patient with a mild emotional disturbance.

Since these patients can walk to the bathroom, to their meals, and to the diagnostic and treatment facilities of the hospital, the services required are chiefly educational and supervisory, as suggested by the examples above. The medical, nursing, and dietary staffs encourage and assist the patients in meeting most of their own needs, and when possible, teach them to take their own medications and simple treatments.

It should be possible to follow a homelike routine, with no fixed bedtime or arising hours except as may be required by appointments for diagnostic or therapeutic procedures, etc.

The nurse is responsible for arranging the patient's schedule and for seeing that he understands what he is to do. She can teach good health practices and plan for health maintenance in the home. She works closely with the phy-

'In the intermediate care unit, emphasis needs to be placed on teaching the patient about his illness and on motivating him to get well.'

sician to give the patient emotional support as well as the specific information he needs to learn to accept his diagnosis or the limitations imposed by his illness, if it is one like diabetes, peptic ulcer, or coronary disease, which he will have to live with indefinitely. Such counseling helps ease the transition from hospital to home.

The professional nurse on this unit will have a minimum of technical procedures to perform, but her human relations skills may be used to the maximum, in counseling, teaching, and providing emotional support. Skills in these areas, knowledge of good public health practices, and of the community's health resources, should be given high priority in selecting the nursing staff for this unit.

The objective is to provide facilities as homelike as possible, consistent with privacy for the individual patient and convenience of facilities. It seems possible to achieve a more homelike atmosphere in a unit that is detached from the hospital, but covered walks should be provided to facilitate patients going to meals and laboratories in bad weather. Single rooms with private toilets are to be preferred. Other spaces might include a small kitchen for preparation of light snacks, recreation room, lounge, conference or demonstration room, physician's consultation and examining room, nurses' station, medicine preparation room and small utility room.

On the self care unit the cafeteria serves as a teaching tool in nutrition education by enabling the dietitian to provide instruction and assistance to the patient as he goes through the cafeteria line.

LONG-TERM CARE UNIT

In our view the general hospital has an important role to play in improving services to the chronically ill, and most communities are inadequately provided with satisfactory facilities for long term patients. Development of a long-term unit within or adjacent to the hospital can not only reduce the need for beds in the acute general nursing unit, but also add to the community's resources for care of long-term patients under good medical and nursing supervision. A survey of the community's needs and resources for care of long-term patients should precede establishment of this type of unit. To achieve its maximum potential the long-term care unit will need to provide services to patients some of whom are now cared for in the general hospital and some of whom are in nursing homes or in their own homes.

Patients will be assigned to this unit who require medical and related services of a character best provided in the hospital, and who are expected to require these services for a prolonged period. They will range from those with a short prognosis for survival but a need for skilled palliative treatment, to those with long-term potential for full restoration of function. They will include also those with a long-term expectation of survival but little potential for improvement; the type of patient generally cared for in the nursing home. Whether a patient will be admitted to this unit may depend in part on the availability of skilled nursing home facilities in the community, and on the patient's home conditions and the adequacy of home care services.

Patients may enter the unit by transfer from the intermediate care unit when it is evident that the convalescence will be a long one, or may be admitted from outside the hospital for a course of restorative or rehabilitative treatment of considerable duration, or merely for palliative or supportive therapy. Examples might include: a diabetic amputee whose wound is healed and who needs diabetic regulation, fitting of a prosthesis and instruction on how to walk, as well as how to care for his remaining foot; a severe arthritic who cannot be cared for at home and who, with a combination of good medical management and skilled physical and occupational therapy has a prospect of improvement in comfort and in activities of daily living; a patient with peritoneal carcinomatosis whose life expectancy is not more than a few months, who requires palliative treatment, periodic paracentesis to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort; an accident victim in a body cast who requires maximum assistance such as turning and feeding, but who has passed the acute phase when intensive care was required. The bedfast cardiac or the senile patient who cannot be cared for at home may also be cared for on this unit.

It must be recognized that the long-term care unit therefore may serve two quite different types of patient, those who need hospital services, over a long period, to achieve a goal of rehabilitation or restoration of functions, and those whose goal is limited to maintenance of comfort and morale. These two groups have in common a need for continued care under skilled supervision, but the degree of skill and intensity of care varies widely.

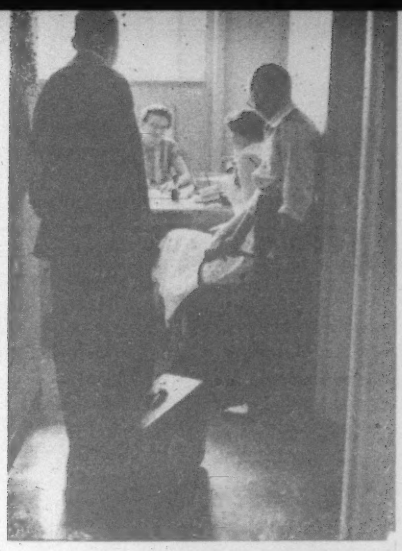
Skilled medical supervision is needed with special interest in geriatrics, orthopedics, and rehabilitation. There may be time-consuming treatments such as constant wet dressings, or the frequent turning of a patient in a body cast. Many patients will need assistance in transferring from bed to chair or stretcher, or help with braces. Some will need assistance with eating as well as with many aspects of personal care. Part of the rehabilitation plan should be to help these patients help themselves, even though this takes a great deal of time.

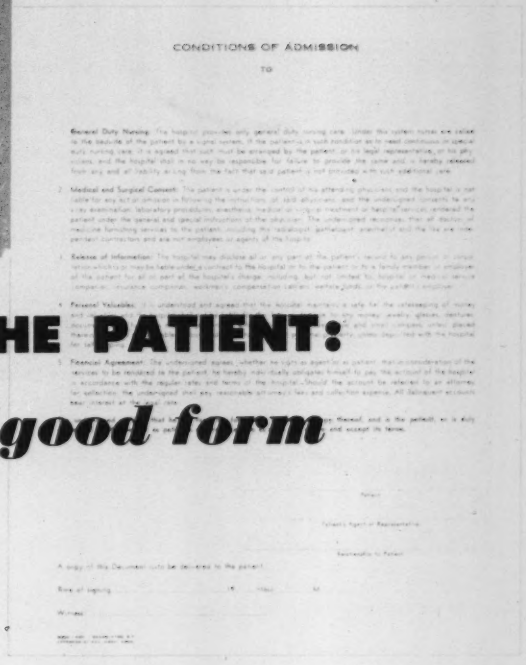
The assistance of a diversional, recreational therapist, and of hospital volunteers may be of value in maintaining morale and motivation toward recovery.

Staff selected for the unit should be individuals who do not become discouraged by the slow progress of the patients on the unit who suffer from chronic illness. The care of these patients involves assessing medical, social, personal, and psychological factors as well as the details of the patient's disability. Therefore, the nursing staff selected must be prepared in nursing in its broadest aspects. There is need for the application of psychological, social, and judgmental skills along with those of a technical nature. Nursing practices must also focus on educating, assisting, and motivating patients to help themselves.

The long-term care unit may be in, or adjacent to, the hospital.

(Continued on page 142)




CONDITIONS OF ADMISSION

ADMITTING THE PATIENT:

a matter of good form

by JAMES E. LUDLAM

THE FIRST official contact that most patients have with a hospital is the hospital admission form. Sometimes this is the only document they sign during their entire admission.

In any event, this form establishes the basic legal arrangement between hospital and patient, and may be the subject of exacting scrutiny in the event of trouble. Unfortunately, many hospitals treat the very existence of such a form as unnecessary red tape foisted on hospital administration by the whims of the legal profession. For this reason the form is often outdated and treated as a stepchild.

In 1954, the author was given the assignment of preparing a standard form for use by California hospitals. As a first step, some 50 forms in current use were procured for examination. Since it is assumed that the forms were all designed to accomplish the same basic purpose, the wide variance in content and language was startling. It was immediately apparent that little thought had been given to the many changes which have occurred, both in hospital administration as well as in court decisions.

Recent court decisions, changes in hospital administration and previous forms have been carefully considered in the development of the admission form described. The form has been tested and used by members of the California Hospital Association and revised in the light of their experiences and suggestions. The final form and the thinking behind it are detailed by the author.

Few hospitals recognized the problems presented by the fact that a large percentage of the hospital bill is now paid from third party sources or that the courts have created new areas of liability that must be faced by hospitals. However, by distilling the various ideas found in the forms as well as drawing on the author's personal experience, a model form was drafted. It was then circulated for comment and criticism to hospital attorneys, legal counsel for medical societies, and many hospital administrators. The final result of many constructive suggestions was then drafted and circulated in late 1954. The form has been in continuous use since that time by many California hospitals. It was again revised in 1957 to take advantage of three years of experience. The perfect form has yet to be drawn, but perhaps a review of thinking that went into our form will help others who are still using a "gay nineties" edition.* For clarity, each section of the form has been quoted in boldface type and followed with a pertinent discussion.

Each word and phrase in the form has some significance. Every effort was made to reduce the length to a minimum. The form is entitled "Conditions of Admission". This is basic to the approach

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*Local legal counsel however, should be consulted before a hospital adopts a form similar to the one described in this paper, as this form is designed to conform to California laws.

New mask reduces threat of wound contamination

NEW surgeon's mask deflects exhaled air posteriorly. A replaceable filter insert inside the mouth section traps moisture and bacteria.

A new surgical mask has been developed at the research laboratories of the General Hospital Research Foundation in Minneapolis, as part of the Minneapolis General Hospital's campaign against staphylococcus infections. Made of flexible polyvinyl plastic, the mask can be washed with any soap or detergent and sterilized with any cold disinfectant in common use.

Developed by Dr. Claude R. Hitchcock, chief of surgery at Minneapolis General Hospital and associate professor of surgery, University of Minnesota, and Dr. Joseph Kiser, a resident at the hospital, the mask was tested at the hospital. It was designed to reduce the threat of contamination of surgical wounds from the noses and throats of operating personnel.

Comparative bacteriologic studies were made in which the subjects wearing various kinds of mouth protection, breathed for five minutes, then coughed once on pour plates held 12 inches from the face. In a series of five tests, breathing through the new surgical mask produced an average of 1.2 colonies of bacteria after 24 hours' incubation. When a pour plate was held six inches from the posterior vent for five minutes, an average of 5.8 colonies grew. Breathing through the single-gauze type mask produced an average of 145 colonies; through a double gauze mask, an average of 43 colonies, and without a mask, 300+ colonies.

The exhaled air from the nose and mouth of the wearer is directed against a specially designed, highly absorbable filter insert, demonstrated in the accompanying photograph. The insert, molded in the mask, is placed within the special chamber at the beginning of the operation and discarded when the mask is removed. The simple tie strings can be pulled from the mask during the time of cleansing, if desired.

It is estimated that this mask, given adequate care, should last for several years. The durable plastic material is soft enough but yet retains a significant amount of firmness so that it gently snugs the face and is an effective seal. The air chamber which is designed into the mask, and which prevents close contact of the skin except at the edges, makes it cool and comfortable to wear. Another feature is the prevention of fogging of the wearer's glasses.

Two mask sizes are available—one for men and a smaller one for women. ■

used in the document. It is not a contract by the hospital to furnish services. Therefore, the language "admission agreement" is not used. This approach is intended to preclude certain claims. For example, if an admission form is construed as an "agreement", hence a contract, an attorney might sue the hospital for breach of a written contract to furnish services. The statute of limitations for contracts is four to six years in many states, considerably longer than the period during which suits must be brought on grounds of negligence.

General Duty Nursing:

The hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians, and the hospital shall in no way be responsible for failure to provide the same and is hereby released from the fact that said patient is not provided with such additional care.

This paragraph has become increasingly important in recent years. For the most part, general hospitals are treating a higher percentage of seriously ill patients. An increasing number of patients are requiring special duty nursing. At the same time, the cost of special duty nurses has reached a point where many families cannot afford them. By and large, insurance has not resolved this problem. The use of intensive care units has not as yet been sufficiently widespread to act as an adequate substitute. The paragraph is designed to prevent the attending physician from forcing the responsibility for providing special duty nursing onto the hospital. Some doctors have adopted the unfortunate practice of charting the fact that the patient needs special duty nursing care without making it clear to the family that it is a family responsibility. The existence of such an order places the hospital in a serious position from a liability point of view when the family refuses to cooperate. If the hospital orders the nurses, there is always the question as to whether they will be paid; and if not, is it the duty of the hospital

to fill the gap or put an additional burden on the floor nurses who are already fully loaded?

Medical and Surgical Consent:

The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that all doctors of medicine furnishing services to the patient, including the radiologist, pathologist, anesthetist and the like are independent contractors and are not employees or agents of the hospital.

This paragraph has been reworked many times. A great deal of material has been worked into these few lines. The fundamental purpose of the section is to provide a blanket medical consent for the protection of the hospital, hospital employees, and the attending physician. It is not a consent to any specific procedure. When a patient is to be subjected to major surgery or hazardous diagnostic procedures, a special consent should be obtained in which the special procedure is designated. The general form covers all routine diagnostic procedures, medical treatment, and minor surgery. Without such a consent the hospital or its employees run the risk of liability for an assault and battery upon a patient. If the hospital does not have such a signed consent and is sued for injury to the patient, the hospital can be sure of having the issue of consent as an additional hurdle to face. One hospital recently spent five weeks in trial over the issue of an oral consent. The hospital eventually won, but it was an expensive victory.

The language also clearly establishes the responsibility of the attending physician to furnish adequate orders for the diagnosis and care of his patient. This helps relations between the hospital and medical staff because it makes clear that the hospital has no intention of interfering in the professional acts of its medical staff. This is further borne out by the specific provisions relating to the radiologist, pathologist, and the anesthetist. In recent years plaintiffs' attorneys have been increasingly successful in holding the hospital liable for the negligence of these specialists on the ground that the patient did not know they were independent contractors. In law this is known as the doctrine of "ostensible agency" and under this doctrine what the patient may reasonably believe controls over the actual factual situation.

Release of Information:

The hospital may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the hospital or to the patient or to a family member or employer of the patient for all or part of the hospital's charge, including, but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds, or the patient's employer.

With increases in third party coverage, the hospital must be in a position to comply with legitimate requests of Blue Cross, insurance companies, and the like for information. Requiring special consents from the patient and the attending physician for every request is an unnecessary burden on the office of the record librarian. The legal implications of the use of this procedure have been more fully covered in a previous two-part article.* As indicated in this article, the actual extent of the provision should be worked out with the medical staff.

Personal Valuables:

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping.

This provision should be revised to comply with the individual laws of the particular state. The language used is adapted to comply with the terms of the Innkeeper's Law in California, which has been amended to include hospitals as one of the organizations that is fully protected for the loss of items kept in the room—provided that the patient has been given notice of the availability of a fireproof safe at the hospital business office.

Special attention should be given to the references to "glasses" and "dentures." The loss of these two particular items has been a source of constant aggravation in hospitals. We haven't quite resolved the question of how to have patients eat a good dinner while his dentures are kept in the vault, but the language does help when the patient is trying to hold the hospital responsible for loss or damage of his glasses or dentures when it was his own fault.

Financial Agreement:

The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

The language of this provision has been carefully drafted to cover as many of the financial problems as possible; for example, it provides for the following situations.

1. *Either the patient or the person who admits the patient is liable for the bill.* Under the Statute of Frauds, an agreement to pay for the bill of another must be in writing.

2. *There is a provision for attorneys' fees.* Unless there is a written agreement to pay attorneys' fees, there is no binding agreement to pay them. This is particularly important in assisting the hospital business office in collecting past due accounts. A reference to this provision in the contract has a salutary effect on many reluctant debtors. If it is necessary to file suit for collection, such a provision reduces the ultimate loss on the account.

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*HOSPITALS, J.A.H.A., July 16 and Aug. 1, 1957.

A bacteriologist asks:

HOW EFFECTIVE ARE CHEMICAL GERMICIDES IN MAINTAINING HOSPITAL ANTISEPSIS?

A RECENT check of the Department of Agriculture's registration files showed that manufacturers hold at the present time approximately 7000 registrations on products for which antimicrobial claims are made. This includes about 450 products whose labeling bears specific recommendations for hospital applications. These figures do not take into account distributor registrations and the fact that some products are sold under 200 or more distributor brand labels.

It is surprising that only about 6.5 per cent of the total number of registered antimicrobial chemicals bear labeling carrying hospital use recommendations. This may be due to a number of factors, one of which is undoubtedly the Department's insistence that evidence of effectiveness against both gram negative enteric bacteria and gram positive pyogenic bacteria be presented with all products carrying directions for such applications.

There does not seem to be uniform agreement among professional hospital personnel as to the proper role of chemical germicides in maintenance of antiseptic conditions, the author observes. A great deal needs to be done toward evaluating the effectiveness of the large number of germicides and other sanitizing agents now being offered to hospitals, he states.

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This article is adapted from a paper presented at the Institute on the Prevention and Control of Infections in Hospitals, University of Minnesota, September 1958.

ECONOMIC POISONS

All sterilizers, sporicides, germicides, disinfectants, and sanitizers, except those sold for use solely on or in the living body of man or animals are classed as economic poisons, as that term is defined in the Federal Insecticide, Fungicide, and Rodenticide Act. They must be registered with the Department of Agriculture before they can be shipped legally in interstate commerce.

This act requires that the labels for all economic poisons bear net content and ingredient statements in prescribed forms, the name and address of the manufacturer or distributor, a suitable product name, necessary caution and warning statements and adequate directions for the uses recommended.

The law does not provide for the pretesting of products prior to registration. Thus, registration of proposed labels are issued fol-

by L. S. STUART

lowing review by an assigned staff of specialists to determine compliance. The Department may demand complete revelation as to formulation and the submission of satisfactory experimental data to support the adequacy of the proposed caution and warning statements, and the validity of the claims made, if this type of information is required for accurate evaluations by the reviewing staff. It should be emphasized, however, that the manufacturer is responsible for the claims made and that these claims are subsequently checked on official samples collected by USDA inspectors.

Unfortunately, there does not appear to be uniform agreement among professional hospital personnel as to the proper role of chemical germicides in hospital programs for the maintenance of antiseptic conditions. Thus, no minimum performance specifications for disinfectants for instruments, thermometers, surgical equipment, laundry, ward applications, floors or walls bear the endorsement of any official organization of the medical or hospital professions. In the absence of specific recommendations by such groups, the USDA has adopted such minimum performance requirements for hospital germicides as there was reason to believe could be supported in court.

LABEL REQUIREMENTS

The law specifically requires that products give the results claimed when applied as directed. If this is found not to be true, then the product is in violation of the law, and the shipper is subject to prosecution.

The only chemical which has been accepted for registration under the law as a sterilizing agent for hospital use is ethylene oxide gas, with directions for its application in specially constructed chambers or autoclaves. Refusal to accept other chemical preparations as sterilizers has been based on failure to show that such materials will, when used as directed or under the customary conditions of application, provide for sterilization, i.e., kill all bacteria including the most resistant bacterial spores.

Some chemical preparations have been accepted for registration for the cold disinfection of instruments under labeling bearing sporicidal claims. Where the manufacturer has been able to demonstrate that such preparations will be effective against the spores of certain organisms of possible significance, then a sporicide claim is accepted in the labeling provided the directions clearly indicate the type of exposure necessary to obtain this result and identify the specific spores against which the product will be effective.

The requirement that all germicides and disinfectants recommended for hospitals must be effective against gram negative enteric bacteria and gram positive pyogenic organisms, when used as directed, automatically eliminates certain classes of germicides, such as pine oil disinfectants, from consideration for hospital use. Pine oil disinfectants are not effective against staphylococci and streptococci.

Label claims for effectiveness against organisms and viruses other than gram negative enteric and gram positive pyogenic bacteria may be accepted for registration with hospital germicides, provided there is reason to believe that the claims are true or the manufacturer supports his application with satisfactory experimental evidence to show that the claims are true.

With hospital preparations, the most commonly proposed claim of this class is a representation for effectiveness against *M. tuberculosis*. Many germicides currently used in hospitals are ineffective against this organism. Since this property may have special significance in routines designed to promote antisepsis in tuberculosis sanatoriums and contagious disease wards in all hospitals, it would seem important to the consumer to have information on this point. Thus, the manufacturer is permitted to supply this type of information on the label.

The Department of Agriculture has held that those situations in which a sanitizing result short of actual disinfection would be likely to have practical value in hospitals have not been clearly defined and that such recommendations for use of chemicals giving such a result must be supported by actual clinical evidence of effectiveness in use. There are many specialty products of this type for which registration applications are continuously being filed. If such products can be shown to be capable of contributing to the desired level of antisepsis in hospitals, they should, of course, be given consideration. However, the burden of proof relative to the existence of practical values must be borne by the manufacturer.

During the last 15 years, a great deal of attention has been given to the control of air-borne bacteria as a means of reducing the incidence of air-borne infections. Some rather extensive hospital installations involving vaporizing devices, air conditioners with built-

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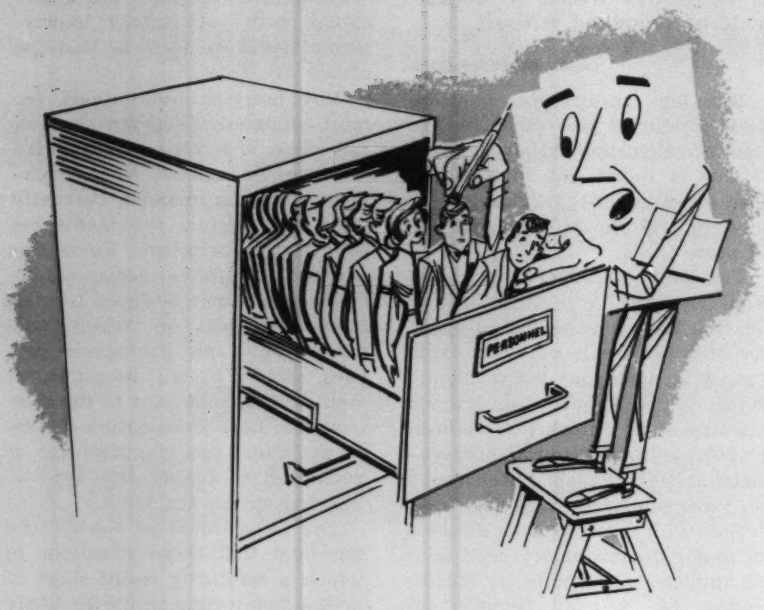
This inventory takes stock of

by DONALD R. NEWKIRK



DEPARTMENT HEADS, administrator, and board need to be constantly aware of the vital statistics concerning movement of employees onto and off the payroll. The most logical method of reporting these statistics is the periodical report or "personnel inventory", which should ideally be concise, accurate, and easy to read.

The "personnel inventory" discussed in this article fulfills the above requirements and is especially useful in small hospitals that do not have a personnel officer or department. The form requires not more than half an hour to complete if done by the same person each month, and is so simple a clerk-typist can do the job after instruction. To further speed up the operation, it is advisable, if possible, to have the same person who tabulates supporting data for the personnel inventory also complete it.

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The author describes the use of a monthly personnel inventory form that serves as a permanent record, alerts the administrator to staffing irregularities and is a valuable interdepartmental communications tool.

COMPILATION OF INVENTORY

Statistics for the inventory are collected in the following manner:

Column 1—Totals (full-time equivalent).

This column contains statistics carried over from Column 4 of previous reporting period.

Column 2 and 3—Terminations and Additions.

The completion of the second and third columns entails counting and entering terminations and additions, by department. A central file should be used for all employment records; if a centralized system is not in use, there is probably a reference file of all employees at some central location in the hospital. This file serves as a statistical clearing house for traffic to and from the payroll, and regardless of whether a system of reporting is in use, some procedure would be necessary to remove records of terminating employees and add records of new employees.

Statistics for the termination and additions column may be collected from the central personnel file by one of the following methods:

1. Keeping a list of terminations and additions by department, as they occur.
2. Setting up a file labeled "terminations and additions" and placing interim personnel records in them. At the end of the report period, these records are tabulated and entered on the personnel inventory.
3. Entering terminations and additions as they occur on a copy of the personnel inventory used as a work sheet.

Column 4—Totals (at end of reporting period).

This column shows the number of full-time employees, part-time employees, and full-time equivalent. Full-time equivalents are obtained by computing the average number of hours worked by part-time employees, and converting this average to a full-time equivalent.

MEMORIAL HOSPITAL, FREMONT, OHIO

Personnel Inventory for Month Ending _____ 19____

% Turnover For Period

DEPARTMENT OR CLASSIFICATION	(1) TOTALS (FT EQUIV)	(2) TERMINATIONS FT	(2) TERMINATIONS PT	(3) ADDITIONS FT	(3) ADDITIONS PT	(4) TOTALS FT	(4) TOTALS PT	(4) FT (EQUIV)	(5) QUOTA (FT EQUIV)	REMARKS (REASONS FOR TURNOVER)
Administration										
Canteen										
Dietary										
Laboratory										
Laundry										
Maintenance										
Medical Records										
Pharmacy										
Physical Therapy										
X-Ray										
Nursing - General										
Central Supply										
Housekeeping										
Nurse Aides										
Obstetrics										
Practical Nurses										
Surgery										
Textiles										
TOTALS										

Total Number of Employees –

Example: If 15 part-time employees worked an average of 20 hours per week, the full-time equivalent would be 7.5 employees.

It has been found that the conversion factor usually remains fairly constant, and for this reason is computed only two or three times each year.

Column 5—Quota (Full-time Equivalent).

Quotas for each department or classification may be used, once set up, until work loads change enough to require an increase or decrease in complements.

To establish quotas, compute the total number of 8-hour shifts required to adequately staff a job for one week. Divide this total by 5 (based on a 40-hour week) to obtain the number of full-time personnel required.

Per cent Turnover for Period.

This figure is obtained by use of the following formula:

$$\text{Turnover} = \frac{\text{Separations}}{\text{Total number of employees (full and part-time)}} \times 100$$

From study of the personnel inventory form, it becomes apparent that once employees are counted and categorized (column 1), a conversion factor is obtained (column 4) and quotas are established, the monthly preparation of statistics becomes a simple matter of addition and subtraction (columns 2 and 3).

USE OF PERSONNEL INVENTORY

The personnel inventory is an "all-purpose" form, not meant to be completed, filed and forgotten. It does serve, of course, as a permanent statistical record of additions to and terminations from the payroll; this use would more than justify the form, but there are other inherent advantages:

1. It is difficult, and many times impossible, for administrators to be cognizant of personnel requirements in each department. The quota column of the personnel inventory form provides the administrator with a "built-in" control system if administrator approval is made mandatory for original quotas when the form is first put into use, and any quota changes thereafter. As the inventory crosses his desk, the administrator simply checks the quota column against departmental totals to pick up conditions of understaffing or overloading.

2. An important indication of trouble in a department is an excessive amount of turnover. Use of the personnel inventory provides a list of terminations *by department*, thus making it impossible for a department with a high turnover record to merge with low turnover departments in a percentage for the entire hospital. If the administrator feels that terminations are excessive for any one department, he should be provided with a supplemental report outlining reasons for termination for each employee leaving the department.

The personnel inventory becomes a useful communication tool when used in meetings of department heads or trustees. The completed form may be summarized verbally or circulated; in so doing, each person gains a knowledge of each department and their relationships. ■

HEALTH CARE IN HAWAII

by **SUMNER PRICE, M.D.**

Caring for a plague-stricken populace set the pattern for the leading public health role now played by Hawaiian hospitals

PUBLIC HEALTH standards are high in the Hawaiian Islands today, but during the last century it was a different story. Sailing ships brought people of all races and diseases, and since the Hawaiian people had never had contact with most of the contagious diseases, they had acquired little or no immunity against such imported maladies as smallpox, diphtheria, typhoid and the like. An epidemic of smallpox in 1853 and a plague epidemic shortly thereafter almost decimated the native population.

The Board of Health was founded in 1850. It was apparent that a hospital was needed to take care of the scourges which struck the natives, and the Queen's Hospital was founded in 1859 in answer to a need for facilities to care for natives struck down by the diseases brought by their visitors.

The contrasting picture of today is very favorable. Tropical diseases are rare, as are all types of dysentery. No deaths in Hawaii have been reported from tetanus in the past 8 years; none from whooping cough in 11 years; one

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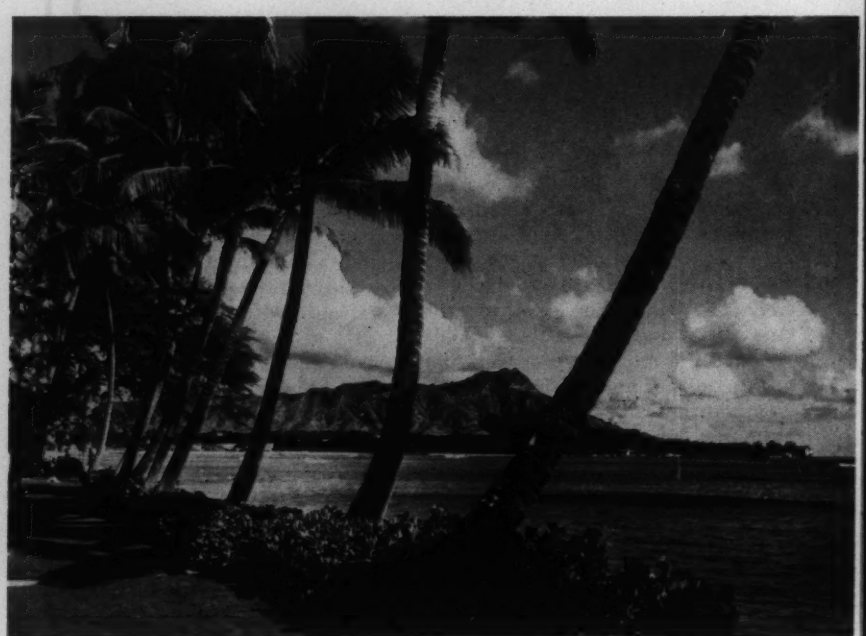
An excellent public health program has moved Hawaii a long way from the decimating plagues and scourges of the 19th century, according to the author. He discusses the history and variety of hospitals on the islands, noting that the usual hospital problems, in some cases, are intensified by local conditions.



The Young Building is part of Leahi Hospital for tuberculosis. The hospital census has steadily decreased due to improved therapy and earlier detection.

Captain Cook's paradise

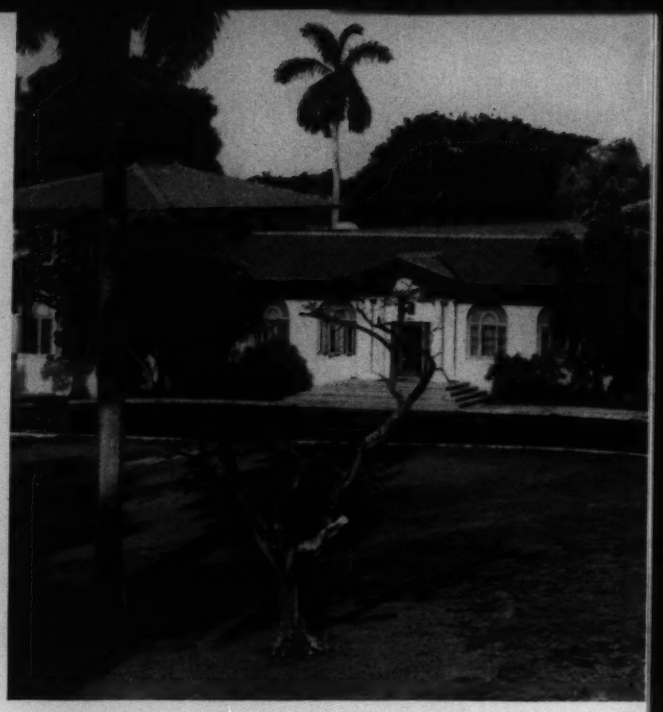
ORIGINALLY A monarchy and first known as the Sandwich Islands, the Hawaiian Islands were discovered by Captain Cook in 1778, and, in 1820, settled by New England missionaries sent to convert the some 300,000 heathen Hawaiians. The monarchy vacillated in its loyalties between strong attachments to England, France, and Russia. The state flag has a remarkable resemblance to that of Great Britain, the state song sounds something like a "Finlandia" with Hawaiian words. Names of prominent streets have an English flavor: Beretania, Cooke, Lusitana; commercial firm names end in "Limited" instead of "Company." As Stephen Vincent Benet said in *John Brown's Body,*

"They tried to fit you with a [foreign] song
And clip your speech into the English tale.
But, even from the first, the words went wrong,
The catbird pecked away the nightingale."

American missionaries had a marked influence on the final petition of Hawaii for annexation to the United States. At first rejected by President Cleveland, the request for annexation was later accepted by President McKinley in 1899. Stanford Dole, the pineapple magnate, was the first appointed governor. Hawaii has waited for statehood for 60 years.

The new state-to-be is an island chain 400 miles long, with the island of Oahu as its center.

The island chain rises from 15,000 feet below the surface of the sea to towering peaks which rise to 13,600 feet into the sky. According to legend, the green-covered mountains were thrust out of the Pacific by the fire goddess Pele during some bygone



geological age. They are surrounded by incredibly light greenish-blue shore waters which turn deep blue beyond the reefs where the inky depths show a topping of white frothy wind-blown surf. On the islands, lush vegetation is everywhere: the multi-hued shower trees, the red lehua, blue jacaranda, orange and red poinciana, the coral tiger claw, and the pink bombax, the beautiful and fragrant ginger and jasmine, and the carnations and plumeria that make up the flower leis.

On the island of Oahu, the modern vacation mecca, Waikiki, is only 10 minutes from downtown Honolulu and the harbor where whaling ships of the last century put in. Bright double-hulled catamarans knife their way through the sparkling waves, while surfers ride their boards to the sands. Nearby, time-weathered lava-stone buildings are still carrying on a world-wide commerce. Further away is a Chinatown of small shops crowded with every imaginable Oriental curio, a mixture in smells of fish, incense and myrrh. A fairy tale palace, the home of royalty during the last century, and the only such building ever built on American soil, is now the seat of the legislature.

The new section of Honolulu has spacious office buildings and stores, and there is a new $15 million shopping center on the Ala Moana. Its cosmopolitanism is reflected in centers of culture: a museum interprets the old Hawaiian themes; an academy of art bridges the motifs of old Hawaii, the Occidental, and the Orient; a superior amateur theater group presents Broadway hit plays; the community's symphony orchestra plays works of world-renowned composers.

The people of the islands represent all races and combinations of races and nationalities: Hawaiian, Japanese, Chinese, Korean, Philippine, Portuguese, Puerto Rican, Samoan, and Caucasians from everywhere, all contributing elements of their various civilizations.

Hawaii is the "big island" where volcanoes still rumble and occasionally spout forth red torrents of brimstone and lava; towering Mauna Loa and Mauna Kea are snowcapped during the winter months. The land is marked with lava tubes and colored by towering tree ferns, and bright red and yellow ohelo berries.

Maui is the second largest island. The varicolored and spectacular craters of its extinct volcanoes are surrounded by rich sugar cane plains. Black coral is raised from depths where lack of oxygen produces the ebony color prized for jewelry.

Kauai, the garden island, spills over with luxuriant tropical flowers, pikaki, ginger, plumeria; its Waimea canyon of colors is equal to Arizona's.

Molokai, known for years for its leper colony, is the scene of many a writer's romantic narrative. The smaller islands are Lanai, famous for its pineapple plantations; Kahoolawe, uninhabited except for goats and antelopes and used as a gunnery target by the armed forces; and Niihau, privately owned, and populated chiefly by full-blooded Hawaiians who have had little contact with the outside world.

—SUMNER PRICE, M.D.

The Queen's Hospital, Honolulu, has 400 beds and is now expanding with a $4.5 million building program.

Shriner's Hospital for Crippled Children, Honolulu, has 30 beds.

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death from diphtheria in 13 years; no deaths from typhoid in 12 years (and but two cases in the last 5 years); and not a single case of smallpox in 46 years. The venereal disease rate is low, thanks to a strong public health program.

Only about 17,000 pure Hawaiians remain out of the original 300,000. Now the over-all population approaches 613,000. Health standards are now such that the perpetuation of the race should be guaranteed except for the common diluting effects of interracial marriage. Nearly all babies born in Hawaii are born in hospitals.

There are no specific diseases peculiar to the new state, although the racial composition is such that the study of certain diseases as to prevalence on a nationalistic and ethnological basis should be of interest to a country interested in improving its international relationships, especially in Asia. This kind of study would be practical geographically, because each county is separated by water. There are no roads to permit a daily interchange by car; inter-island travel is by airplane or boat.

PHYSICIANS

Approximately 500 physicians are licensed in Hawaii. In Honolulu there are 130 physicians who have been certified by the various U. S. specialty boards, and a sprinkling of such certified personnel are on other islands. Since 1935 Hawaii has required graduation from an acceptable medical school for licensure. Certification by the National Board of Medical Examiners is recognized. Internships and residencies are maintained in the larger hospitals in Honolulu so that local and mainland personnel may receive accredited specialized hospital training up to four years in surgery and pathology; three years in internal medicine, psychiatry, and obstetrics-gynecology; and two years in pediatrics. This training qualifies personnel for examination by the respective American specialty boards.

Nurses training is carried on by two hospitals with diploma programs, and by the University of Hawaii, which conducts a degree program in nursing, using local hospitals for clinical training. Three hundred nurses are in training in all three institutions. The state supports a school for practical nurses. Educational standards for nurses are high. In competitive examinations, student graduates have ranked with the upper 10 per cent of the United States, according to past records of the National League for Nursing.

Technicians serve an internship in the larger hospitals after three years at the University of Hawaii. They receive their degree in medical technology and are then eligible, after examination, for registration by the American Society of Clinical Pathologists. Medical technologists are licensed by the state. One hospital conducts a course in x-ray technology.

HOSPITALS

A total of 6065 hospital beds are listed by the American Hospital Association.

Beds	Type of Hospital
1234	State mental hospital
110	State facility for mentally retarded
315	State facility for Hansen's Disease (2)
978	For tuberculosis (525 in three county facilities and 453 in one private facility)
265	City and county chronic disease facility (1)
1200	Army facility (1)
95	Private nonprofit, OB-Gyn (1)
100	Private nonprofit, childrens' (1)
40	Private general (1)
542	General hospital beds (5 county facilities)
135	Plantation hospital (4 facilities)
1273	General beds (8 nonprofit facilities and one church-operated facility)

In addition to the above there is a new unlisted rehabilitation facility of 20 beds, a convalescent hospital of 65 beds, plus 10 or more unlicensed nursing homes,

and a new hospital of 150 general beds.

This total represents 12 nonprofit private facilities, 9 of which are accredited by the Joint Commission on Accreditation of Hospitals; 4 plantation facilities, of which 3 are accredited; 6 county hospitals, of which one is accredited; 4 tuberculosis hospitals, 2 of which are accredited; an accredited state hospital for mental diseases; and the army hospital, which is accredited. Thus 4420 of the available beds are in accredited hospitals.

Hospital Services—Among the hospital services available presently or in the near future are televised surgery, 2-million-volt x-ray therapy, isotopes, artificial kidney, open cardiac surgery, experimental surgery, audiometric facilities, centralized radio, postoperative recovery wards and small units for short-term psychiatric care in two of the general hospitals.

One hospital is constructing 10,000 square feet to be devoted to research laboratories under partial grant from the National Institutes of Health. Present activities include virus and tissue culture laboratory, studies in hormones, and fat metabolism as it relates to arteriosclerotic lesions. Future work includes expansion of the study of strains of poliomyelitis and related viruses; biological chemistry; chromatography; enzymes and related subjects. Hawaii has set the pace for a medical center in the Pacific that some day may be of international interest.

First Hospitals Develop—The first hospitals in the Islands were a far cry from what one considers a hospital of today. The British, the French, and later the U. S. Marines had hospitals in name, but originally they were little more than thatched areas behind the "grog shops" in which drunken sailors could lie until they recovered. There was no place for the Hawaiians to go, and the indigent Hawaiians with their multiple lesions from syphilis and other acquired diseases were an eyesore to the populace, as well as an embarrassment to the royal families.

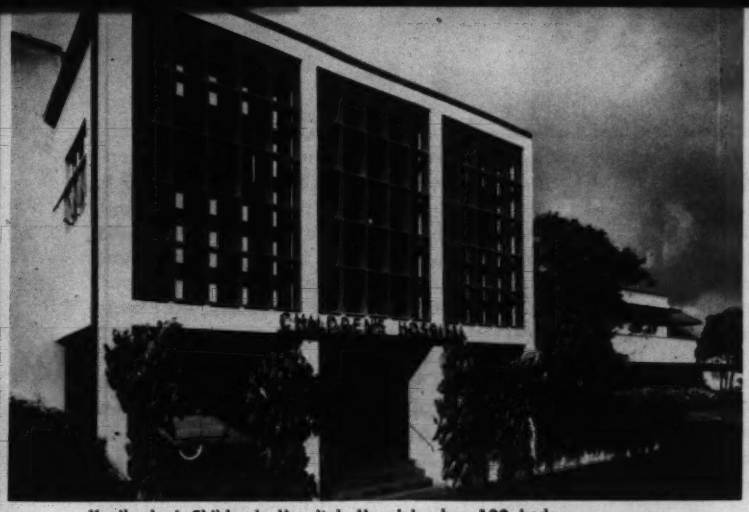
After years of unsuccessful effort to obtain funds from the legislature, his majesty Kamehameha IV and Queen Emma went on a door-to-door canvas, and in a short time they solicited $13,000. The incident shamed the legislature into appropriating an additional $6000 to construct the first real Hawaiian hospital. A two-story structure of coral block containing 140 beds, it was appropriately named "The Queen's Hospital". The local newspaper criticized the sponsors for having constructed such an extravagant building and commented they should have better constructed thatched huts to which the natives were much more accustomed.

A physician was appointed and rates were established at 75 cents per day (wine and watchers extra). No nurses were introduced until 1886; no interns or residents until 1902; no electricity until 1905; no x-ray until 1911. The first class of nurses graduated in 1919; the intern program was approved by the AMA in 1924, physiotherapy was established in 1925; a psychiatric unit was first organized in 1930; occupational therapy and medical records departments were organized in 1931; an electrocardiography machine was first used in 1936. A blood bank established in 1941 supplies the entire island chain and fills local army requirement. Today the hospital has the facilities of a major medical center. It has been designated as the base hospital in state disaster planning. Queen's Hospital, like most other general hospitals in Hawaii, conducts outpatient clinics for the indigent.

The second hospital to be found-

Lanai Community Hospital, the only hospital on the island of Lanai, has 25 beds and serves approximately 2200 people.

Waialua Sugar Plantation Hospital Oahu, with 40 beds, is a typical plantation hospital.



Kauikeolani Children's Hospital, Honolulu, has 100 beds. The Rehabilitation Center of Hawaii is on the same grounds.

ed (1891) by royalty was the Kapiolani Maternity and Gynecological Hospital, which was "to assist in the perpetuation of the Hawaiian race". Queen Kapiolani and King Kalakaua, the last king of the Hawaiian paradise, were the benefactors. The hospital has had an enviable record of low maternal and fetal mortality for a number of years.

Kuakini Hospital, originally organized as the Japanese Hospital in 1900, also conducts a nursing home for elderly Japanese men. During World War II it was taken over and controlled by the armed forces, and renamed the Kuakini Hospital. After the war it progressed, and it is now fully accredited.

Kauikeolani Hospital founded in 1909, is a modern structure with excellent facilities for the care of children, and is now conducting an aggressive educational program by importation of mainland specialists for three to four months at a stretch. In addition, the grounds house the Rehabilitation Center of Hawaii.

Shriner's Hospital (1923), for crippled children, is supported by funds raised at an annual football game plus other funds subscribed by the Shriners.

The Sisters of St. Francis first came to the islands to assist Father Damien in the Kalaupapa leper colony. Having performed such outstanding services of mercy, they followed by the founding of the St. Francis Hospital (1927), a modern, progressive, general hospital.

Wahiawa General Hospital (1945) is located in the heart of pineapple fields of Oahu.

Leahi Hospital (1901), for tuberculosis, has a depleting census, with 100 or more vacant beds compared to the long waiting list for admission of 10 years ago.

Rural hospitals include Southshore, Ewa and Kahuku.

Hale Mohalu is devoted to the care of patients with Hansen's Disease.

Tripler Army Hospital is a well organized, accredited hospital with intern and resident training. It is estimated that the facility cost in excess of $50 million, a monument to the combined services that use it.

County Hospitals—The islands were blessed initially with many plantation hospitals supported by the sugar industry. Only four such hospitals remain, but three of them are accredited. The county hospitals are gradually taking their place. Central Maui Memorial (1952), an accredited facility on the island of Maui, is an example of a consolidated community activity. Kula Sanitorium (1910) cares chiefly for the tubercular. The pineapple island of Lanai, a part of Maui County, has its Community Hospital.

Molokai, although attached to Maui County by government, has its Community Hospital, and the Kalaupapa Settlement (1865), around which the name of Father Damien is closely woven.

On the island of Kauai, Wilcox Memorial is an accredited nonprofit institution that has served the island since 1938. Veteran's Memorial at Waimea is a new county hospital, and the Samuel Mahelona Hospital serves primarily in the area of tuberculosis.

On the island of Hawaii, county hospitals predominate. The general hospital Hilo Memorial was combined with Puumaile (tuberculosis) in 1951. Several plantation hospitals closed with the opening of the new Honakaa Hospital (1951). Kohala plantation hospital has been converted from plantation to county control, as has Kona Hospital. Pahala Hospital remains essentially a plantation-supported hospital.

ADMINISTRATION PROBLEMS

Problems of hospital administration in Hawaii are of the same general nature as on the mainland, although as might be expected, some of the problems are intensified by conditions peculiar to Hawaii.

Capital Funds—There are difficulties in obtaining capital funds for improvements. Because of a high per capita income, which gives little consideration to high living expenses, only minimal federal funds have been available for matching purposes. Hill-Burton funds have been available to Hawaii on a variable basis approximately $200,000 per year and $300,000 in Wolverton funds. At times, the distribution has caused tensions between hospitals competing for the funds available. Such tension is complicated by the reluctance of business concerns, banks or insurance companies to loan money to charitable institutions. Until recently, our insular position worked against loans because various state laws forbade loans outside the continental United States. Statehood should improve this situation; mainland capital has been moving into the islands with considerable rapidity the past year.

"Medicare"—Tripler Army Hospital cares for all military personnel as well as military dependents. The "medicare" program increased the census of maternity patients in the private hospitals for a year, but with the curtailment of "medicare" the army hospital is again bursting at the seams with more

than 4000 births per year. (Births dropped to 1800 a year during the extensive use of medicare.) Veterans have free access to the hospital by signing a paper of medical necessity, which cannot be reviewed. The civilian hospitals have adjusted to this situation so that it doesn't seem to constitute any particular threat at present. A minimum of anxiety exists over a possible disgorgement of nonmilitary patients on short notice, as did happen in 1941.

Indigent Care—Originally the monarchy assessed a head tax of two dollars on every person entering the kingdom. This tax was turned over to the Queen's Hospital to support indigent medical care. In 1908 the legislature repealed the "head tax" law and took over the support of indigent care by subsidy to any hospital. In recent years the legislature has appropriated funds on a biennial basis to the board of health, which has reallocated the funds to the various counties, and each county has in turn reimbursed the hospitals on a fee-for-service basis. This system has in the past provided a high grade of patient care for the indigent and has been effective in providing payment to hospitals.

At present, however, Honolulu hospitals find themselves in a ticklish political situation in which proponents for a local city and county hospital are claiming before the legislature that they can provide acute care at a per diem cost of $14.02 per patient day, which is less than half of the present cost in the private nonprofit hospitals. The merits of the case aside, strained public relations have resulted.

Recruitment of Personnel—Recruitment of personnel for higher level positions is difficult because of the expense involved in arranging personal interviews and because it takes time to process applications with reasonable care. Positions are available in limited numbers for well qualified clinical instructors and teachers in the nursing schools and for well trained supervisors. Because of the limited number of positions available in a specified area, applications must be kept on file for future reference. This complicates personnel procedures.

At present there is not an acute shortage of staff nurses such as exists in many mainland centers. Three factors combine to produce an adequate supply: (1) Many wives of military personnel apply for work in civilian hospitals. (2) Three nursing schools graduate approximately 100 nurses per year —enough to meet the immediate needs of hospitals. (3) The natural attractions of Hawaii draw nurses to the Islands, at least for a year or so of service. On the other hand, there is a 50 per cent turnover per year at the staff nurse level.

A unified recruitment program for student nurses is carried island-wide into nearly all high schools on "Career Day." At this time a bid is made for students in the upper quarter of their classes. Student applicants are screened with appropriate aptitude tests and college entrance examinations; the accepted students are of a high caliber and the attrition rate is low.

Interns and Residents—Interns and residents are recruited from several sources. One hospital, for example, accepts only U. S. graduates as interns; another is now accepting graduates of Japanese schools who are certified by the Educational Council for Foreign Medical Graduates and another hospital is accepting graduates of Philippine and other foreign schools who have been certified by ECFMG. Only one hospital participates in the National Intern Matching Plan. Residents are easier to obtain, but the distance away from home complicates recruitment. About 50 per cent of the interns and residents coming to Hawaii remain.

The Future—Attraction of hospital personnel to Hawaii should be easier in coming years. Air transportation has seemed to assist in easing the anxiety of going so far away from home, and with the coming of jet planes which will probably be in service next year, Hawaii will be something like 10 hours from New York.

The underseas cable, established last year, makes it practical to dial almost any telephone in the United States within 30 seconds. This has also lessened the feeling of isolation and increased our own sense of belongingness to the Union. Language is not a major problem for English-speaking personnel because one soon learns to understand "pidgin" even though there may be an initial difficulty in speaking this interesting and affected "lingo." During the past 60 years, as a Territory, all except immigrants have attended schools conducted in English.

Physical Plant Maintenance—Steam is used for utilities. For practical purposes there are no heating problems in Hawaii. Heat is needed only to provide water and steam for utilities and appliances. Air conditioning is growing in importance and is becoming a major maintenance problem. Air conditioning is not found in most hospital rooms because of the "free" ventilation. Rooms are screened, of course, but flies are minimal and mosquitoes are limited for the most part to several weeks during spring rainy season. Cockroaches and termites require a continuous control program, but they can be controlled, as can the seasonal ants. There are no snakes, and rats and mice are handled about the same as anywhere else.

Organizations—The Hawaii Hospital Association meets annually and the trustees meet quarterly. The Honolulu Council of Hospitals meets monthly. All accredited hospitals on the island of Oahu are eligible for membership, and personal membership is available for others actively interested in the hospital field. A series of five hospital institutes has been jointly sponsored by three or more of the following organizations: the American Hospital Association, the Hawaii Hospital Association, the Honolulu Council of Hospitals, the Pan Pacific Surgical Association, and the National League for Nursing. Several hundred students have registered; at one of the most successful, there were approximately 500 registrants. Prominent personnel in the hospital field from the mainland have contributed to the success of these programs. Two institutes have been sponsored by the Association of Western Hospitals. In the planning phases are the 1960 institute in conjunction with the Pan Pacific Surgical Congress and another in 1961 with the Association of Western Hospitals. ■

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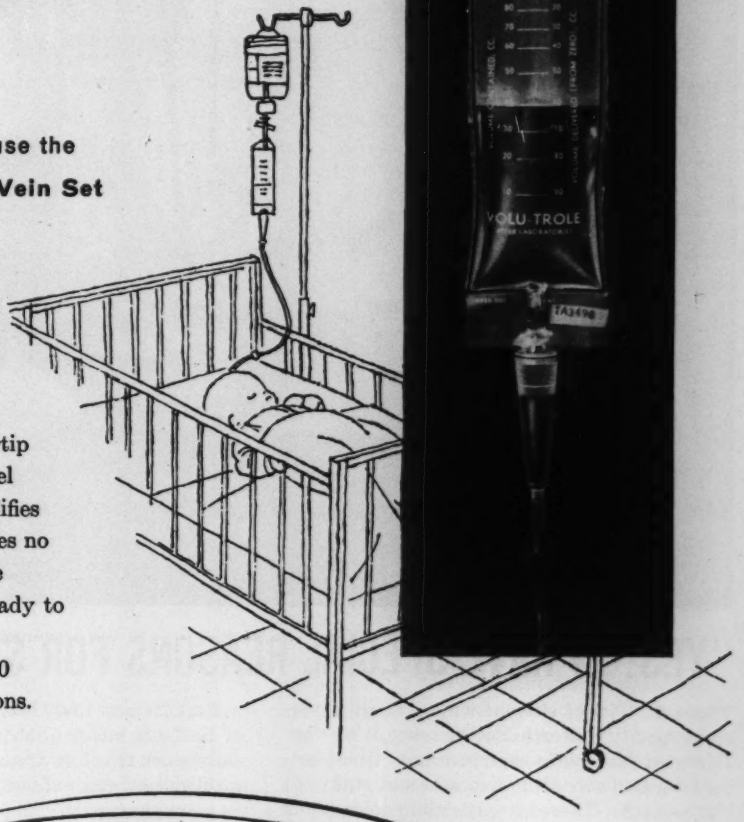

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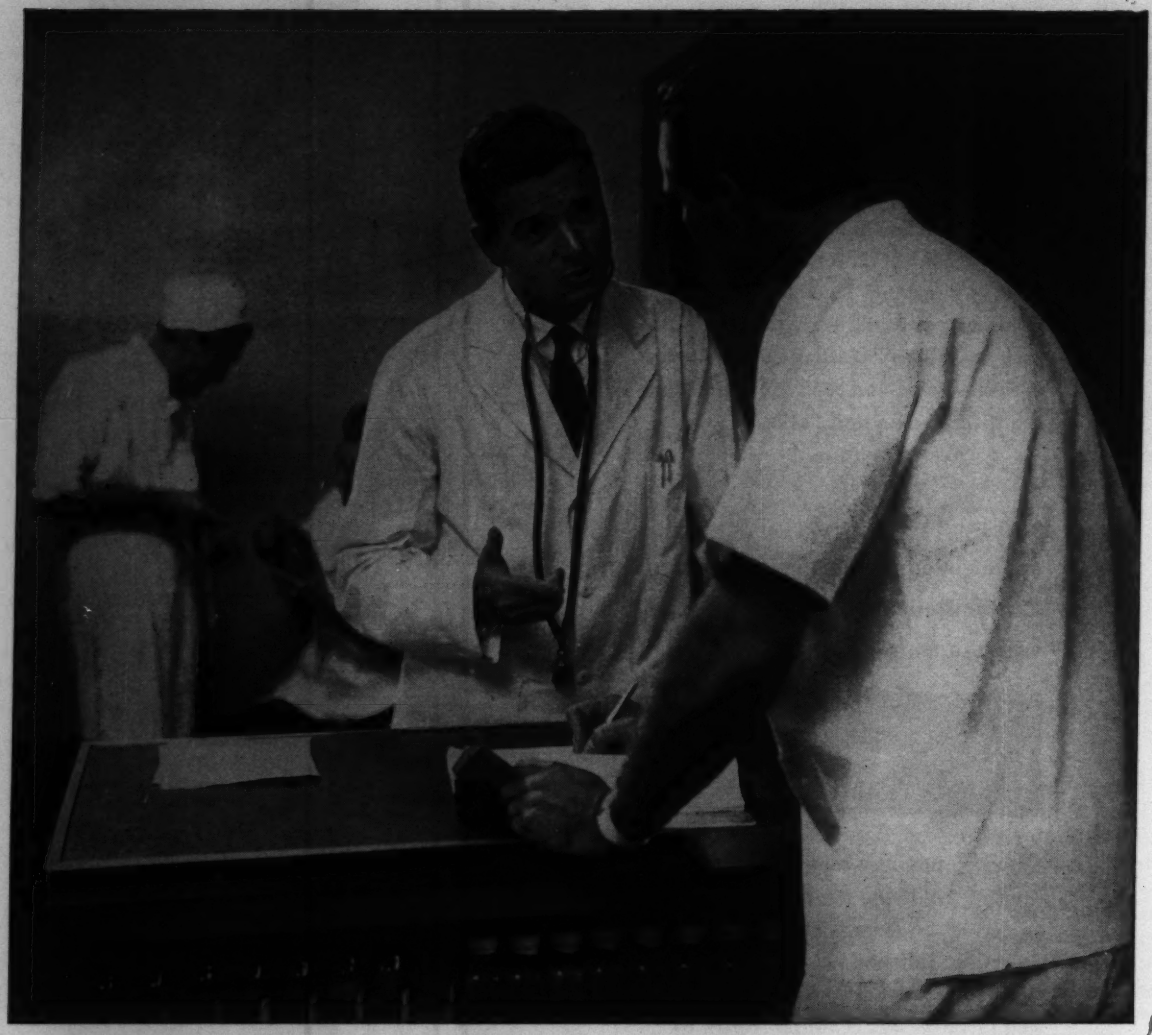

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1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

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HOW EFFECTIVE ARE CHEMICAL GERMICIDES IN MAINTAINING HOSPITAL ANTISEPSIS?

(Continued from page 47)

in filters, air washing solutions, and ultra-violet lamps have been installed with a view to reducing cross infections. There are wide differences of opinion as to the practical value of such installations in promoting antiseptic conditions.

Although it is possible to show that such installations do reduce the bacteria and virus particle counts of air in closed spaces and will reduce the incidence of airborne infections of animals in experimental chambers, it has been impossible to correlate these results with decreases in upper respiratory infections in clinical studies on human populations.

It appears, therefore, that the incidence of infection in humans, in or out of hospitals, is so much higher from sources other than air that it is not possible to demonstrate statistically any clinical value in antimicrobial air treatments. Nevertheless, triethylene glycol and dipropylene glycol preparations have been accepted for registration for sanitizing air and reducing the bacterial and virus populations of air with directions for its application in suitable vaporizing devices with continuous or intermittent operation. These chemicals are active against bacteria in the vapor phase only. No claims for sterilizing or disinfecting air have been accepted. Also, numerous germicidal formulations have been accepted for disinfecting air in air-washing tanks built into air-conditioning systems.

No objections have been raised to air-sanitizing claims or other antibacterial claims of a mitigating nature in the case of properly installed ultra-violet light devices. The Department of Agriculture's position is based on the belief that although the plus value of such treatments may be very small, the general public will not be injured, provided (1) claims and representations are held at the mitigating level and (2) acceptance at this level makes it possible for hospitals and institutions to purchase such materials for use in special situations in which professional personnel believe they have merit.

Bacteria carried from one person to another in droplets of saliva by coughing and sneezing should not be confused with so-called airborne bacteria. These bacteria are characterized as fomites and infections so induced are classed as direct contact infections. Fortunately, such droplets settle out of the air very rapidly and are seldom carried more than four or five feet from the mouth or the nose. The face mask serves to control the source of this type of infection in hospitals. Treatment of the materials used in fabricating such masks with germicidal chemicals has frequently been proposed. There is no substantial evidence that such treatments would be valuable.

Dust-borne bacteria must also be differentiated from air-borne bacteria. Infections due to such organisms can be controlled by effective dust control measures. Significant reductions in infections in army barracks were brought about through the use of oil treatments for blankets and bedding. In these experiments, no antibacterial chemicals were employed and the positive clinical results had to be ascribed solely to the physical dust-suppressing properties of the chemicals employed.

Bacteriostatic chemicals are now commonly added to sweeping compounds and oil treating emulsions for dust cloths and blankets. The actual practical value of these additions in the over-all problem of antisepsis is presently being studied in a number of institutions. It is not probable that a result at the disinfecting level can be obtained by any of these additions. However, the manufacturer is entitled to make such claims for these preparations as can be demonstrated to be true.

SURFACE DISINFECTION

It seems reasonable to suppose that the proper use of selected chemical germicides in disinfect-

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ing room utensils, ward equipment, sanitary fixtures, furniture, floors, and walls would contribute materially to any program directed to the maintenance of antiseptic conditions. In general, it can be stated that surface germicides should be applied after cleaning to disinfect. This type of application circumvents the inactivating effects of organic soils and assures contact between the bacterial cells and the disinfecting solution. However, the advantages of this type of application may be nullified if residues of incompatible cleaning compounds are present.

Unfortunately, many available germicidal preparations are poor cleaners. When such products have been used in maintenance cleaning programs, the poor result in visual cleanliness as compared to conventional cleaning compounds has frequently discouraged continued acceptance. Germicide manufacturers are now attempting, with considerable success, to build in cleaning properties equivalent to those found in heavy duty detergents. Some of these newer formulations seem already to have found wide acceptance as general hospital disinfectants.

Quaternary ammonium, synthetic phenol-soap emulsion, cresylic acid-soap emulsion, and acid nonionic detergent-iodine complex formulations make up a large percentage of the products which have been accepted for general disinfections in hospitals. Some hypochlorite and essential oil-soap formulations have also been registered for this use.

Although these products may all be capable of disinfecting surfaces if properly applied, their real value in the hospital program for the maintenance of antiseptic conditions probably depends upon the arrangement of suitable application routines. We know of no preparation which will provide surfaces that are actively self-disinfecting in use, although some will leave bacteriostatic residues. Under certain conditions, this property may have some mitigating value in the over-all maintenance program.

Numerous antibacterial chemicals are being recommended for use in the hospital laundry. As laundry disinfectants, hypochlorite bleaches and quaternary ammonium formulations are most frequently proposed, although some phenol preparations are also recommended.

As opposed to actual disinfection, a rather wide variety of chemicals has recently been proposed for the treatment of laundry to impart residual bacteriostatic properties. The principal values attributed to such treatments are: odor control with incontinent patients and in soiled linens held for laundering; prevention of ammonia formation from urine soils, and the maintenance of low counts in bedding, surgical drapes and gowns during periods of high humidity and high temperatures leading to excessive perspiration.

No treatments of this type have been encountered which will provide self-disinfection of fabrics in use. Chemicals commonly proposed to provide residual bacteriostatic activities include mercury preparations, tributyl-tin, quaternary ammonium compounds, and bisphenols.

For thermometer and instrument disinfection, preparations of ethyl, propyl and benzyl alcohol are frequently employed, the latter usually applied with an organic mercurial. Quaternary ammonium, nonionic detergent-iodine complexes, formaldehyde, synthetic phenol and cresylic acid preparations are also used for this purpose.

Neither rubbing alcohol nor surgical scrub soaps are classed as economic poisons, subject to regulation under the Act, unless they are shipped under labeling bearing directions for use on inanimate objects. This is seldom the case.

Investigations have indicated, however, that these products are quite commonly employed for disinfecting articles and surfaces in hospitals. If rubbing preparations contain 70 per cent alcohol there would be no reason to doubt their effectiveness in this respect. Surgical scrub soaps containing hexachlorophene, actamer, 2,4,5, trichloro carbanilide or tetramethyl thiuram disulfide may or may not be good surface disinfectants.

If the chemicals are present in sufficient concentration and proportioned correctly to the soap content so that the medicated soap will act as a germicide in cleaning, a good result may be expected. However, if the chemical is present in concentrations providing only bacteriostatic activity, a poor result or failure of the disinfecting process can be anticipated.

In this connection, it might be proper to call attention to the fact that it has been clearly demonstrated that bacteria in a state of chemical stasis are capable of inducing infections in living animals.

Even though mercury preparations have high bacteriostatic potency, they are poor germicides, especially where staphylococci are concerned. This fact was reported by the Food and Drug Administration as early as 1934 and has been verified many times. Such products do appear to be cidal at high dilutions for fungus spores so that they might even be classed as specifics for this type of infectious agent. Use in hospitals should, therefore, be restricted to specific decontamination projects for such agents, odor control through bacteriostasis and the like.

Paint manufacturers are currently offering bacteriostatic, fungistatic, and self-sanitizing paints for walls. It is claimed that such paints will contribute materially to the control of wall surfaces as reservoirs of infectious agents. In many instances, manufacturers have obtained the endorsement of hospital officials.

The proper scientific evaluation of these claims involves a number of difficult testing problems. Obviously, there are limits to the number of times that walls can be washed and disinfected, and if these new paints can be found to reduce materially the role of walls and ceilings as carriers of infectious bacteria, then they may find a real place in the hospital program.

In a somewhat similar manner, flooring material manufacturers currently are exploring the possibility of incorporating antimicrobial chemicals in their products. Here again, the level of activity which can be expected and the actual practical contribution to the maintenance program remain to be demonstrated.

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hospital germicide application studies. Advances in our knowledge of surface-active chemicals, sequestering and chelating agents, and the chemistry of bactericides are such that the chemical industry can, within reason, provide specific formulations which will be effective for almost any cleaning and sanitizing situation. However, in the absence of the type of information which can be developed only in well planned application studies, products will be produced continuingly on the basis of such empirical information as the manufacturers may be able to assemble. ■

NOTES AND COMMENT

Infection study stresses simple preventatives

Any hospital area can be made clean by repetitive and intelligent mechanical effort in conjunction with a good disinfectant-detergent, according to a recent article in the Journal of the American Medical Association*. This clean area will remain clean until contamination is brought into it.

Extensive studies into the sources of infections also showed that "the bacterial contamination of air in a room can be significantly reduced by daily application of proper cleaning techniques. An efficient air-conditioning system can readily be made to deliver dust-free, nearly sterile air into a room under positive pressure. Such air, delivered into a clean room, will remain nearly sterile indefinitely, unless contaminated by introduction of infection. This is introduced by exhalations of personnel entering the room and by fomites from clothing, shoes or objects brought in.

"Air contamination of a room by human exhalation is at least 98 per cent preventable and controllable by proper filter masking of all people entering the room."

The authors were emphatic in their emphasis on the fact that even a two-minute exposure to an outside exposed area was enough to produce contamination of clothing and objects and result in the contamination of a clean room. It was stressed that contamination of any clean room was inevitable unless employees rigidly obeyed stringent regulations regarding maskings, freshly sterilized clothing and shoe wrappings.

The only practical clothing answer for the prevention of the contamination of clean rooms was found to be a "double-breasted, wrap-around, quick-change, lace-tying gown." Every reentry into the clean area must be preceded by a gown change. "If used where there are flammable gases, the garment must be constructed of a material which will not produce static electricity."

The same precautions must be applied to shoes, and a temporary shoe covering was recommended. Again, if exposure to flammable gases is involved, conductive soles must be a part of the shoe.

The authors continue with a discussion of the prevalence of wound infections contracted in the operating pavilion "from entry into the wound of germs from the air or from fomites about the personnel and patient, including those of the patient's skin . . . A sterile skin surface can be achieved by 10 minutes of diligent scrubbing with germicidal detergent soap and water. The sterility of this surface can be maintained indefinitely by the proper application of an adherent transparent plastic film."

The authors conclude with the important observation that "critically competent supervision and working personnel with attitudes of dedication to maintenance of cleanliness are necessary . . . For nine-tenths of the hospital a good housekeeper with an eye for dirt and an ability to get it removed is a better investment than complicated bacteriological testing equipment and routines. For the other one-tenth of the hospital area, meaning essentially the operating pavilion and the nursery, standards, controls, and fulfillment must be of the ultimate type from which no appeal for leniency is tolerable." ■

*Adams, R., Fahlman, B., Dube, E. W., Dube, F. J. C., and Read, S. *Control of Infections within Hospitals: special reference to prevention within operating rooms.* *J.A.M.A.* 169:1557 April 4, 1959

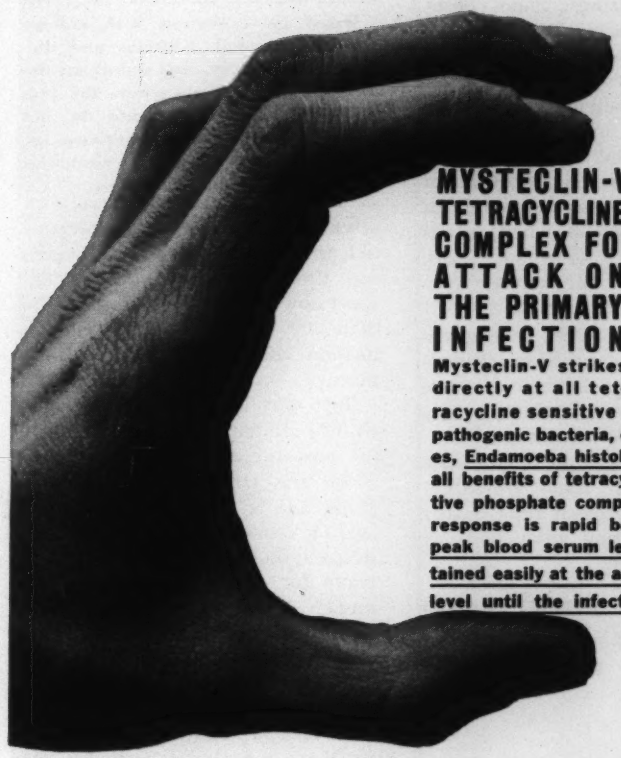
Oral prescriptions permitted for certain narcotics

Federal legislative action now makes it possible in many areas for *certain types* of narcotic prescriptions to be ordered verbally by a registered physician and relieves him of signing the prescription either before or after it is dispensed to the patient. The federal oral prescription law as it applies to certain narcotics (or variations of this law) has been adopted by the legislatures of many states.

The specified requirements which preparations must meet (to be dispensed on verbal narcotic prescriptions) were established under Public Law 729 of the 83rd Congress and are available in General Circular 234, U. S. Bureau of Narcotics. Hospital pharmacists should make note of two factors related to activity on this question. The federal oral prescription law does not authorize the dispensing of narcotics in violation of state and local laws. The applicability of oral prescription for certain narcotics may be counter to established hospital policy requiring written orders on nursing units in the interest of safety of the patient. Classes of narcotics now include: Class A narcotics taxable under full control; Class B narcotics taxable and permitted on oral prescriptions; Class X narcotics preparations which are exempt.

For hospital pharmacists and others, an excellent prescription counter summary chart of the new federal oral prescription regulations for narcotics is available from most state boards or the Mallinckrodt Chemical Works, c/o Narcotics, St. Louis 7, Missouri. Seventeen narcotics are outlined in tabular form with the maximum amount of narcotics or its salt allowable for verbal prescription. Allowable amounts in combination with no other active ingredient, in combinations with benzylisoquinoline alkaloids and in combinations with a therapeutic amount of a nonnarcotic drug are presented in a table for easy reference and interpretation of the provisions of the oral prescription law.—American Professional Pharmacist, *January 1959.* ■

more than tetracycline alone



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Half-strength Capsules (125 mg./125,000 u), bottles of 16 and 100.
Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Cronk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958, p. 397 • 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

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food service and dietetics

WHY ARE THERE SO FEW DIETITIANS?

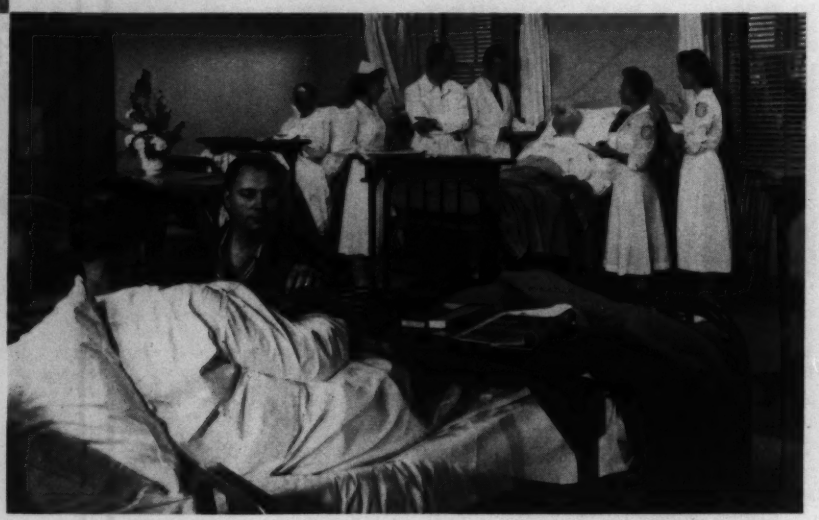
by ALICE J. KIRK

Based on interviews with college students, hospital dietitians and dietitians in industry, this report on the shortage of dietitians covers the reasons why college students do not choose dietetics, why dietitians are leaving the profession and what hospitals can do about it.

AMERICAN business men, beset with a variety of ills, often voice the opinion that "things may have to get worse before they get better". This doctrine can also be applied to the field of education, and it has special merit when one considers the present shortage of dietitians. Insofar as the supply of able dietitians is concerned, things have indeed become worse. There has been a steady drift away from the dietetics field for years.

Hospitals now find themselves in an untenable position. Professionally qualified dietitians are not available. Higher salaries fail to uncover suitable candidates. Part-time personnel are unreliable, and even hospitals that are fully staffed at the present time realize that the situation may be only temporary.

(ABOVE) Dietitian checks over modified diet prepared by dietetic intern. During a one-year internship following graduation from college, the dietetic intern has the opportunity to plan all types of modified diets and is challenged to prepare a diet that each patient will eat and enjoy. (RIGHT) During her internship the young dietitian also visits patients with members of the medical, nursing and dietary staffs to learn first hand their nutritional needs and their needs for diet instruction.



SHORTAGE INCREASES

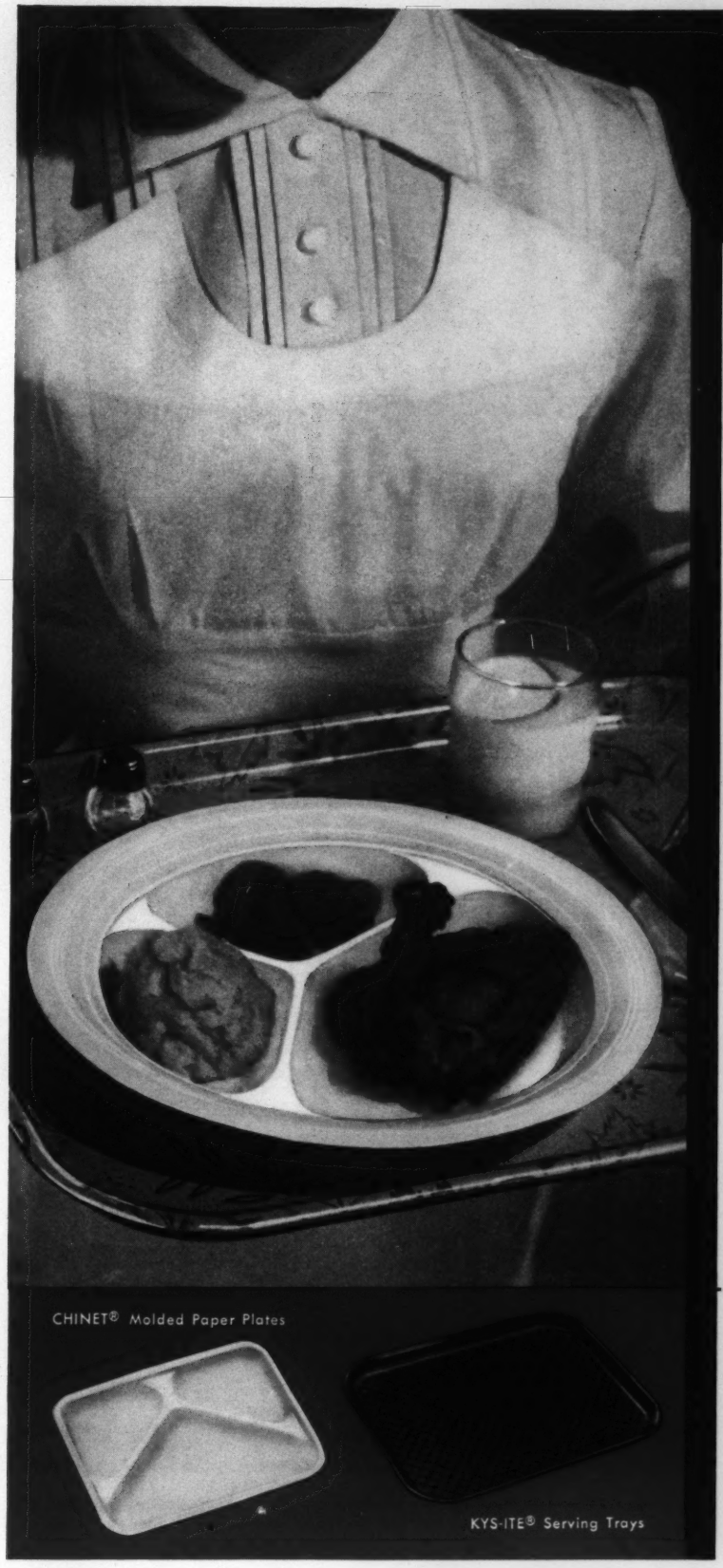
An examination of the 1956-57 picture shows that despite increased hospital expansion and the building of new hospitals with an attendant need for more personnel, the number of interns finishing their fifth year of training went down instead of up; and more than 200 vacancies existed in the hospital internship training programs.*

Just why do comparatively few college students choose to prepare for hospital internships? Why do those who complete their internships fail to enter hospital service? Of those who actually become hospital dietitians, why do so many leave for other types of employment? And last of all, how can colleges and hospitals work together for the good of the dietetics profession?

To gain an insight into what some people believe the answers to these questions may be, the

Alice J. Kirk is dean, School of Home Economics, Stout State College, Menomonie, Wis. This report was distributed by the Wisconsin Hospital Association to all member hospitals.

*During 1958-59 the American Dietetic Association reports there are more than 300 vacancies in the hospital internship training program.



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2. *Kraft Instant Potatoes* hold up extremely well . . . keep their color, taste and texture unimpaired from one serving period to another. Use them not only for mashed potatoes, but for soups, gravies, potato souffles, fish cakes, etc.

Critical chefs who shunned dehydrated potatoes are enthusiastic about *Kraft Instant Potatoes.* Now they also avoid "run-outs."

3. Simple to prepare. No operation to time, no temperature to watch. Bring liquid to boil, add *Kraft Instant Potatoes,* whip, serve.

Before introducing Instant Potatoes, Kraft waited until they had a superior product . . . one that could proudly take its place in the Kraft family of fine foods.

The preparation method—a really major improvement—is simplicity itself. Even inexperienced kitchen personnel can mix a perfect batch of Kraft Instant Potatoes in a few minutes. The method is simple, never fails.

You can serve these new *Kraft Instant Potatoes all year round* for about 2¢ per portion. No more seasonal fluctuations in price or product quality to worry about. And, of course, you eliminate many steps, and save all the time and labor, that raw-to-finish handling involves. No. 10 can yields 150 3-oz. servings.

Once you try *Kraft Instant Potatoes,* you'll appreciate the many advantages of using this new product for all your mashed potato requirements. Write, or ask your Kraft man, for sample packet and recipes.

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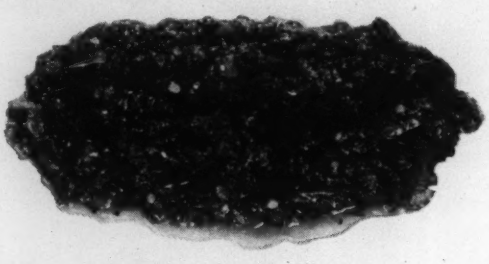
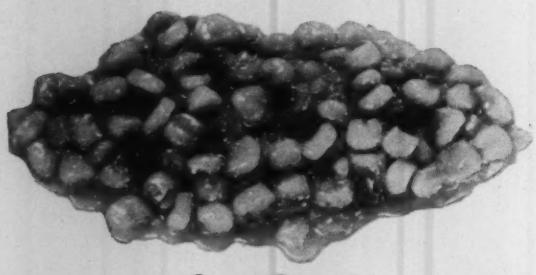
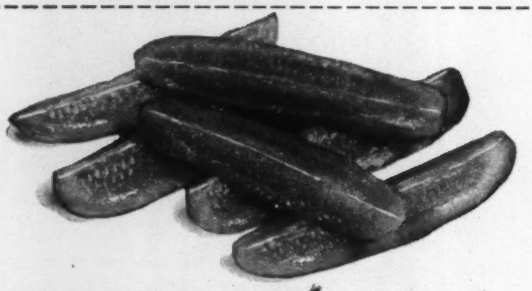


Sweet Pepper Relish

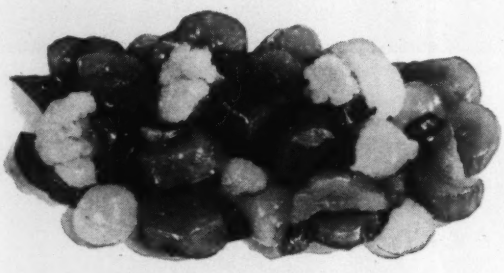


Corn Relish



Home Style Quartered Pickles

Tiny Sweet



Sweet Mixed

Sexton quality condiments are a special blend of original recipes and the very best of ingredients. This combination adds extra zest to menu items that keeps customers coming back again and again. Choose Sexton condiments for the largest variety, the highest quality and the best in flavor.

Sexton *Quality Foods*

writer questioned many undergraduate students, college graduates, hospital dietitians and several professional women who had completed approved dietetic internship programs in various states. All of the members of the latter group had been successful dietitians in small, medium-size or large hospitals for periods ranging from 2 to 10 years. Later, each had voluntarily left her position to accept employment outside the hospital field. The writer has recorded the opinions of all of these groups, aware that not all factors apply to any one situation —but hopeful that the opinions of these students and experienced dietitians serve as a guide toward a more successful recruitment effort and a more realistic evaluation of the dietetics profession.

'NO' TO DIETETICS

Why are not more college students majoring in dietetics? From this survey, the writer found that there were five major reasons. These are:

1. *Dietetics is an unfamiliar field.* College students usually choose to prepare for occupations that they have known about for many years. A review of college admissions indicates that home economics students are most likely to come from rural or small town areas; a locale where few dietitians are employed and where information concerning the profession is limited.

2. *Information about the profession fails to reach groups at the appropriate age level.* Investigation will show that the competing professions have developed effective programs to make precollege girls well aware of the career possibilities in other fields.

3. *The fifth year of internship training is a deterring factor.* Many college students do not have funds to continue their education beyond a bachelor's degree, and others choose not to spend an additional year in training at a time when their co-workers are earning good salaries or getting married, or both.

4. *Discouraging word-of-mouth publicity about hospital dietitians had had an unfortunate effect upon recruitment.* Girls learn about supposed split shifts and long hours from friends and relatives and are reluctant to enter the field.

5. *The rapidly rising rate of early marriages among college students is having an adverse effect upon the dietetics profession.* Many college girls shift into fields which they believe to be more in harmony with the interests of the married woman worker.

REASONS FOR LEAVING

What are the most important factors that make dietitians leave the profession? The following eight reasons were reported:

1. Higher salaries are available outside the hospital field.

2. Dietitians believe that professional and personal advancement is either lacking or extremely limited.

3. Pressure and criticism are fairly constant. Rightly or not, many a dietitian rates her job as a thankless one in comparison with the acclaim given to other members of the hospital staff. Frequently, dietitians are not sufficiently recognized as highly trained professional personnel.

4. In large cities especially, the employment of low caliber kitchen employees results in a constant turnover of the labor force, and this in turn requires continuous retraining.

5. Although a 40-hour work week may be stipulated, longer hours are the rule. A dietitian's responsibilities require that she be away from home at meal times and this presents a problem for the married dietitian. Week-end and holiday duty is disliked.

6. Many dietitians must work under several administrators and, in addition, are on the receiving end of much unsolicited advice.

7. The constant meeting of deadlines, a necessary part of a dietitian's job, is a work feature that especially irks the younger dietitian.

8. The total independence of food processors today results in many incorrect or shorted orders —an additional frustration for the dietitian.

HOW HOSPITALS CAN HELP

In view of these findings, we next asked the dietitians' advice on what can hospitals do to gain and retain their personnel. The following eight suggestions were received:

1. Hospitals should attempt to increase the salaries of hospital dietitians so that these salaries are commensurate with professions requiring five years of pre-study. Apparently the salaries and the selection of other dietary employees should be studied and improved so that a better and more stable working force can be developed.

2. Every attempt should be made to develop better interdepartmental relationships.

3. Hospital administrators might consider the advantage of allowing more time off duty to enable dietitians to attend conferences, workshops and professional conventions. Valuable information is obtained in this way. Attendance at such meetings has the advantage of making a dietitian from a smaller hospital realize that her problems are also the problems of others.

4. The present experiment with food service supervisors and dietary clerks should help relieve the hospital dietitian of routine tasks which now often prevent her from fulfilling her major responsibilities.

5. Many dietitians in army and Veterans Administration hospitals are apparently more content than those employed elsewhere. Two well liked features of the services might be considered for wider use: (a) The regular evaluation of services and some type of professional rating, and (b) specific definition of responsibilities.

6. Many college students who expect later to qualify as dietitians seek summer employment in hospital dietary departments. A satisfying experience at this point can be an amazingly effective recruitment aid.

7. Hospitals and medical groups might well consider the advantage of offering scholarships to persons interested in pursuing internship training after graduation from a college in their particular area.

8. Hospital administrators and dietetic associations should not lose sight of the fact that there is keen competition from other fields for the services of career-minded home economists.

The suggestions and comments

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in this article have been made in the belief that hospitals and colleges can accomplish more when they work together. A cooperative spirit is a strong force for successful achievement. ■

AT ST. LUKE'S HOSPITAL, JACKSONVILLE, FLA.

Continental breakfast builds good will at low cost

GETTING FAVORABLE comments from a patient poll is always gratifying. When the favorable comments become "rave notices" about a hospital food service, it is especially rewarding.

Patients answering the questionnaire about food and general care at St. Luke's Hospital, Jacksonville, Fla., wrote: "I thought that the early morning coffee and sweet rolls were delicious—and a good idea. I also enjoyed the juice between meals."

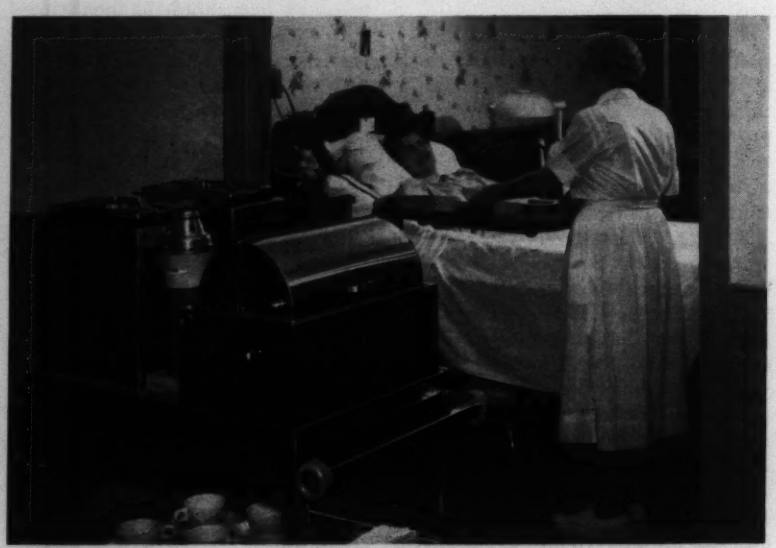
"The 6 o'clock coffee service is just the thing to start the day."

Like most hospitals, St. Luke's was faced with the problem of awakening the patient early for baths and medications, and then keeping him happy until the breakfast service started at 8 a.m.

W. E. Arnold, executive director of the 210-bed hospital, worried about the problem until a chance business meeting in New York gave him the solution. An early riser, Mr. Arnold was delighted to find an insulated container of hot coffee and a hard roll with butter and jelly deposited at daybreak in the service slot of his hotel room. A comparable solution could be effected, he felt, in the hospital by young girls serving pots of hot coffee and buns to all patients who wanted an early snack.

In the spring of 1954 final plans for a "continental breakfast cart" were put into operation. Two high school girls were employed at a dollar an hour to come in at 5:30 in the morning to prepare the carts, one for each of the two floors. By 6 o'clock the girls were dressed in white pinafores over blue dresses and had the carts ready for service on the floors. Each cart is equipped with an insulated container of hot coffee, one of hot water for tea, a warmer filled with hard rolls and sweet rolls, butter and jelly.

In 1956 the high school girls (who had graduated) were re-



DIETARY SUPERVISOR serves coffee and sweet roll to patient at St. Luke's Hospital, Jacksonville, Fla., as part of the hospital's 6 a.m. continental breakfast service established five years ago. Approximately 120 patients request this service each day. The cost is 12 cents per person.

placed by two dietary supervisors, who were placed in charge of the continental breakfast cart and the 10 o'clock nourishment cart. They also supervise the serving of breakfast. Two shifts of supervisors are necessary. The morning shift is in charge of the morning servings; the second shift in charge of the noonday meal and supper meal. The second team also serves the afternoon nourishments and visits the patients for menu suggestions.

A cup of steaming hot coffee and a roll are served to each patient who asks the night before to be put on the pre-breakfast list. Service is not made, of course, if chart orders conflict. Approximately 120 patients request the continental breakfast each day. Obstetrical patients almost invariably take a double order; most men take a second cup of coffee.

Norry J. Lessard, food service manager, reports that the average daily cost of this service is approximately 12 cents per person.

"We feel that this is a small price to pay for a contented patient," Executive Director Arnold said. "The nurses and doctors find the patient more cooperative; the dietary department is well repaid for the extra effort by the enthusiastic reception the service receives; and administration is constantly getting notes about 'that angel who came in at 6 a.m. with hot coffee and a sweet roll'."

NOTES AND COMMENT

Two-week courses for cooks scheduled

While lack of time and funds often prevents employed persons from participating in continuing education programs for the full academic year, the shorter refresher courses conducted during the summer months can be fitted into many schedules. One such example is the two-week refresher course offered by the Culinary Institute of America, a nonprofit, vocational school for cooks and bakers located in New Haven, Conn.

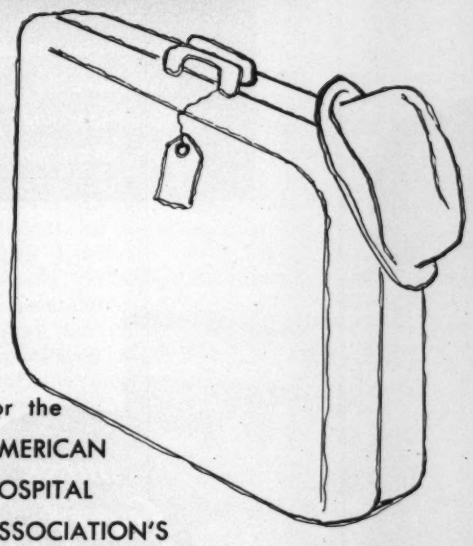
Chefs, cooks and pastrymen with five or more years of quantity food production experience in hospitals, hotels, restaurants, cafeterias and institutions are eligible to enroll. Character references are also required.

This year the course will be held in three sessions: July 6-July 17, July 20-July 31, and August 3-August 14. The courses will be held Monday through Friday from 8 a.m. to late evening.

Tuition for the course is $100. Room and meals will be supplied to students on the campus for $50 per week. This weekly fee includes uniforms, linens, texts, and supplies.

These refresher courses cover the basic foundation of cookery, pastry, baking and related subjects in practice and theory. The cooking course starts with the basic foundation of stocks, soups and sauces before beginning preparation of well known classical dishes with a large variety of spe-

READY ?



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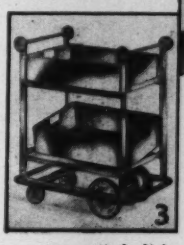

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cialties from every part of the world. The pastry and baking course includes rolls, muffins, breads of every description, classical and well known desserts, pastries, petits fours and confectionery work.

In addition to the Institute faculty, this year's instructors will include the following culinarians: Robert Audelan, secretary of Les Amis d'Escoffier Societe Foundation, Inc.; Georges Blanc, executive chef, The Waldorf Astoria; Eugene Ertle, executive chef, United Airlines; Pierre Franey, executive chef, Le Pavillon Restaurant, New York; Humbert Gatti, executive chef, Hotel Plaza, New York; Gaston Hertrich, president, Societe Culinaire Philanthropique of New York, Inc.; Anthony Lagassi, president, Executive Chefs de Cuisine Association of America, Inc.; and Fred Wohlkopf, president, International Chefs Association, Inc.

For application blank and additional information concerning the course, address communications to The Culinary Institute of America, Angell Sq., New Haven, Conn. ■

Four recipes included with North-Northwest menus

Patients at Sacred Heart Hospital, Yankton, S. Dak., have a number of favorites among the menu items offered at the hospital, reports Sister M. Inez, O.S.B., hospital dietitian. Items most frequently mentioned are pineapple refrigerator cake, cheese cake, baked zucchini and duchess soup.

These menu items are included in the North-Northwest summer cycle menu beginning on p. 78. The recipes for these foods are presented here through the courtesy of Sister Inez.

CHEESE CAKE

(32 servings)

- **6 oz. lemon flavored gelatin**
- **1 pt. boiling water**
- **1 lb. graham crackers**
- **½ lb. butter or margarine, melted**
- **¼ c. confectioners' sugar**
- **1 lb. cream cheese**
- **½ lb. granulated sugar**
- **2 cans (14½ oz.) evaporated milk, whipped**

1. Dissolve gelatin in water and chill until it begins to congeal.

2. Combine cracker crumbs, melted shortening and confectioners' sugar. Place half the crumb mixture in bottom of two, 8 by 12 in. pans. Reserve remaining mixture for topping.

3. Combine cream cheese and granulated sugar. Add cheese mixture and partially congealed gelatin to the whipped evaporated milk and whip thoroughly. Pour into crumb-lined pans. Top with remainder of crumb mixture.

4. Chill several hours or overnight.

PINEAPPLE REFRIGERATOR CAKE

(50, four-ounce portions)

- **10 oz. egg yolks**
- **2 lbs. sugar**
- **1 lb. butter or margarine**
- **8 oz. cream**
- **1⅞ lbs. crushed pineapple, drained**
- **⅓ oz. salt**
- **1 tsp. lemon rind**
- **4 oz. lemon juice**
- **3 lbs. vanilla wafers or dry cake crumbs**
- **9 oz. maraschino cherries**
- **1½ lbs. pecans, chopped**

1. Beat egg yolks thoroughly. Add sugar, butter or margarine,

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SIGN OF GOOD TASTE

cream, pineapple, salt and lemon rind. Cook in double boiler until custard consistency. Remove from heat and add lemon juice.

2. Crush the wafers or cake to make crumbs. Mix with the chopped pecans.

3. Place 1½ lbs. or 1½ qts. of crumbs into bottom of pan (11 by 19 by 2¼ in.) and ¾ lb. or ¾ qt. of crumbs into bottom of pan (8½ by 15 in).

4. Spread 2 qts. (approximately 4¾ lbs.) of filling over crumbs in large pan and 1 qt. of filling over crumbs in small pan.

5. Sprinkle 1½ qts. of crumbs over the filling in the large pan and ¾ qt. of crumbs over the filling in small pan.

6. Sprinkle 1 c. maraschino cherry pieces over large pan and ½ c. over small pan.

7. Refrigerate for 24 hours. Cut contents of large pan into 32 pieces and small pan into 18 pieces.

8. Serve with whipped cream.

BAKED ZUCCHINI

(25 three and three-fourths-ounce portions)

5 lbs. small zucchini squash
½ lb. butter or margarine
½ oz. salt
½ tsp. pepper
½ lb. dry bread crumbs

1. Wash and slice zucchini in halves lengthwise. Arrange in buttered shallow pan.

2. Melt butter or margarine and pour half of it over zucchini.

3. Sprinkle with salt and pepper.

4. Combine remaining butter or margarine with bread crumbs and sprinkle over zucchini.

5. Bake in 350°F. oven for 1 hour or until zucchini is tender. NOTE: Cooked tomatoes may be added before topping zucchini with bread crumbs. Then sprinkle with grated American cheese.

DUCHESS SOUP

(Yield 1½ gal., or 25, 1-cup servings)

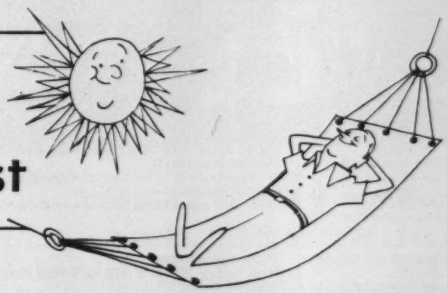
3 oz. quick cooking tapioca
11¼ lbs. hot milk
1½ oz. salt
½ tbsp. pepper
3 oz. onion, minced
¾ lb. butter or margarine
½ lb. mild cheese, grated
½ oz. parsley, chopped

1. Add tapioca to hot milk, stirring and cooking until clear. Add salt, pepper and onion.

2. Add butter or margarine and cheese. Cook until melted.

3. Just before serving, add chopped parsley.

Summer Cycle Menu for the North-Northwest



THE 21-DAY selective summer cycle menu and market orders for perishables are designed for hospitals in the North-Northwest. These menus, which are to be used during June, July and August, feature foods popular in the northern and northwestern parts of the country.

The menus in this issue are the final set in a four-part series of summer cycle menus published in this Journal. Summer cycle menus for the Midwest were included in the April 1 issue of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The South-Southwest summer cycle menus were published in the April 16 issue of the Journal. The East menus were included in the May 1 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

The spring cycle menus, published in the January and February issues of this Journal, are for use during May. The Midwest and South-Southwest cycle menus were included in the January 1 and 16 issues, respectively. The February 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois.

1st WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Sister M. Inez, O.S.B., dietitian, Sacred Heart Hospital, Yankton, S. Dak.

	breakfast	noon	night
monday	Orange or Tomato Juice Farina or Ready-to-Eat Wheat Flake Cereal Poached Egg	Vegetable Soup Roast Leg of Veal (FS) or Meat Loaf—Gravy Whipped Potato (FS) Succotash or Buttered Wax Beans (FS) Pear-Cranberry Salad or Spiced Pear Salad Chocolate Pudding (FS) or Fresh Peach	Cream of Tomato Soup—Croutons Cold Plate—Chicken Salad, Deviled Eggs, Spiced Crabapple, and Lettuce (F) or Creamed Chicken (S) Potato Chips (F) or Baked Potato (S) Buttered Beets or Summer Squash (FS) Frosted Cupcake (FS) or Pineapple Chunks
tuesday	Pear Juice or Stewed Prunes Oatmeal or Ready-to-Eat Rice Cereal Bacon Curls	Split Pea Soup Country Fried Liver (F) or Broiled Beef Pattie (S) Escalloped Potato (FS) Green Peas (FS) or French Fried Onions Molded Fruit Salad or Lettuce Hearts—Russian Dressing Vanilla Ice Cream (S) or Apple Upside-down Cake (F)	Cranberry Juice Cocktail Italian Spaghetti with Meat Balls (F) or Broiled Loin Lamb Chop—Parsley Potato Ball (S) Buttered Green Beans (FS) or Stewed Tomatoes Tossed Vegetable Salad or Minted Pear Half Chocolate Chip Cookie (F) or Peeled Apricots in Syrup (S)
wednesday	Pineapple Juice or Grapefruit Sections Whole Wheat Cereal or Cornflakes Scrambled Eggs and Ham	Beef-Noodle Soup Broiled Steak (S) or Creamed Sweetbreads Mashed Potatoes (FS) Seven-Minute Cabbage or Spinach—Hard Cooked Egg Garnish (FS) Orange-Date Salad or Relish Plate (celery, pickles, and radishes) Boston Cream Pie (F) or Green Gage Plums (S)	Broth Fruit Plate with Cottage Cheese, Toasted Raisin Bread (F) or Soft Cooked Egg—Toast Scalloped Corn (F) or Peas and Carrots in Cream (S) Spiced Peach or Lettuce Salad with Mayonnaise Cantaloupe Wedge or Fruited Gelatin (FS)
thursday	Orange Juice or Sliced Banana Farina or Ready-to-Eat Cereal Soft Cooked Egg Breakfast Roll	Vegetable Beef Soup Roast Beef (FS) or Baked Stuffed Heart Oven Browned Potatoes (FS) Broccoli—Brown Butter or Wax Beans (FS) Peach Fan Salad or Cole Slaw Raisin Crisp or Sugar Cookie and Baked Apple (FS)	Beef Soup Cold Cuts (F) or Sliced Tongue (S) Parsley Buttered Potatoes (S) or Potato Salad (F) Creamed Carrots (FS) or Buttered Peas Spiced Beet Salad or Carrot and Raisin Salad Peaches in Syrup or Vanilla Blancmange (FS)
friday	Grape Juice or Half Grapefruit Oatmeal or Ready-to-Eat Rice Cereal Poached Egg	Cream of Tomato Soup Oven Browned Fish Sticks—Lemon Wedge (S) or Shrimp Salad (F) Potatoes au Gratin (FS) Asparagus Spears (FS) or Vegetable Medley Banana-Nut Salad or Stuffed Prune Salad Apple Pie (F) or Ice Cream (S)	Orange Juice Tuna Fish Salad (F) or Baked Egg in Toast Cup (S) Duchess Potatoes (FS) Buttered Wax Beans (S) or Stewed Tomatoes (F) Sliced Tomato Salad or Lettuce Wedge Fresh Fruit Cup (F) or Oatmeal Cookie (S)
saturday	Orange Juice or Orange Rolled Oats Cereal or Ready-to-Eat Cereal Scrambled Egg Danish Coffeecake	Alphabet Soup Stuffed Baked Pork Chop (F) or Roast Beef (S) Steamed Potatoes (FS) Hot Applesauce (FS) or Mashed Rutabagus Spiced Peach Salad or Fruit Salad White Cake with Fudge Icing (FS) or Watermelon Wedge	Beef-Rice Bouillon Spanish Rice and Bacon Curls (F) or Cottage Cheese (S) Buttered Potatoes (FS) Green Beans (S) or Buttered Broccoli (F) Tossed Salad or Celery Sticks and Olives Canned Peaches in Syrup (S) or Fresh Peach (F)
sunday	Grapefruit and Orange Sections or Orange Juice Malt Meal Cereal or Ready-to-Eat Sugar Coated Cereal Bacon Sweet Roll	Chicken-Noodle Soup Roast Turkey—Dressing (FS) or Broiled Ham Slice Mashed Potatoes (FS) Buttered Green Beans (S) or Cauliflower au Gratin (F) Cranberry Mold or Pineapple-Orange Salad Fresh Strawberry Shortcake (F) or Ice Cream (S)	Consomme Cold Baked Ham Slice—Potato Salad (F) or Roast Beef (S) Baked Potato (S) Glazed Carrots or Asparagus Spears (FS) Fruit Salad or Spiced Apple Orange Cupcake (F) or Canned Pears in Syrup (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverage are to be included with each meal.

PLEASE CUT ALONG THIS LINE

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings				Item, Specifications, Amounts & No. of Servings				Item, Specifications, Amounts & No. of Servings			
BEEF				**PREPARED MEATS**				Potatoes, White	Bag No. 1	400 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	30 lbs.		Assorted Cold Meats		20 lbs.	60	Radishes	Bunch	2 doz.	
Heart		13 lbs.	40	**FRESH FRUITS**				Rutabagas		5 lbs.	
Liver	Steer, sliced	25 lbs.	100	Apples	Jonathan, 113s	2 boxes		Squash, Summer		20 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	45 lbs.		Bananas	Ripe	55 lbs.		Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	25 lbs.	80	Cantaloupe	Crate, 45s	½ crate		**FROZEN FRUITS**			
Sweetbreads	Fresh	12 lbs.	40	Grapefruit	Seedless, 70s	1 box		Apples	Slices, 8 lb. can, 5-1 sugar	40 lbs.	
Tongue	No. 1	7 lbs.	20	Lemons		1 doz.		Grapefruit Sections	8 lb. can	16 lbs.	
LAMB				Oranges	176s	2 boxes		Grapefruit and Orange Sections	8 lb. can	16 lbs.	
Chops, Loin	U. S. Choice, 6 oz. each	8 lbs.	20	Peaches	Basket 20s	5 baskets		Orange Juice	Con., 32 oz. can	6 cans	
PORK				Strawberries	Quarts	12 qts.		**FROZEN VEGETABLES**			
Bacon (Sliced)	24-26-1 lb.	6 lbs.		Watermelon	30-35 lb. av.	35 lbs.		Asparagus	Spears, 2½ lb. pkg.	25 lbs.	150
Chops, Loin	Grade A, 4 oz. each	25 lbs.	100	**FRESH VEGETABLES**				Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Ham (Pullman)	Ready-to-eat	45 lbs.		Cabbage	Bag	50 lbs.		Beans, Wax	Cuts, 2½ lb. pkg.	32½ lbs.	195
VEAL				Carrots	Topped, bag	50 lbs.		Broccoli	Stems and buds 2½ lb. pkg.	12½ lbs.	75
Leg (B.R.T.)	U. S. Good	30 lbs.		Celery	Pascal, 30s	1 doz. stalks		Cauliflower	Buds, 2½ lb. pkg.	15 lbs.	90
FISH				Celery	White	1 doz. stalks		Peas	2½ lb. pkg.	17½ lbs.	105
Sticks, Fish		10 lbs.	40	Cucumbers		1 doz.		Peas and Carrots	2½ lb. pkg.	2½ lbs.	15
POULTRY				Endive	Curly	1 doz. heads		Spinach	Chopped, 2½ lb. pkg.	15 lbs.	90
Fowl (Eviscerated)	Grade A, 5 lb. av.	75 lbs.		Lettuce	Head, 48s	2 crates		Succotash	2½ lb. pkg.	2½ lbs.	15
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.		Onions, Dry	Yellow, bag	50 lbs.		Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15
				Onions, Green	Bunch	1 doz.					
				Onions, Spanish-type		3 lbs.					
				Parsley	Bunch	1 doz.					

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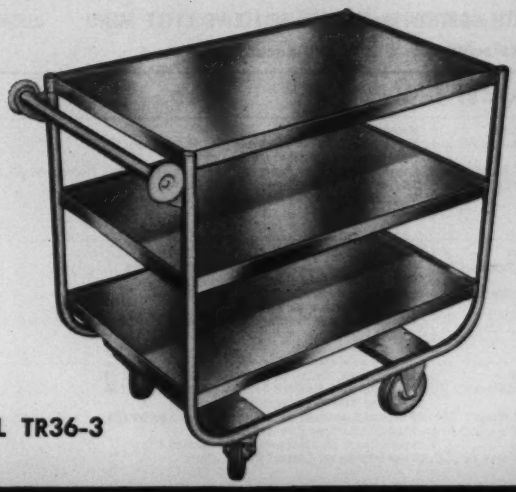
Swartzbaugh Manufacturing Company proudly hails 75 years of making the finest hospital equipment possible with the introduction of IDEAL's new lines of Tray Trucks and Dish Trucks. These trucks have the same high quality of design, materials and workmanship which have characterized Swartzbaugh equipment for three quarters of a century. They are worthy additions to the IDEAL line of the best in hospital equipment.



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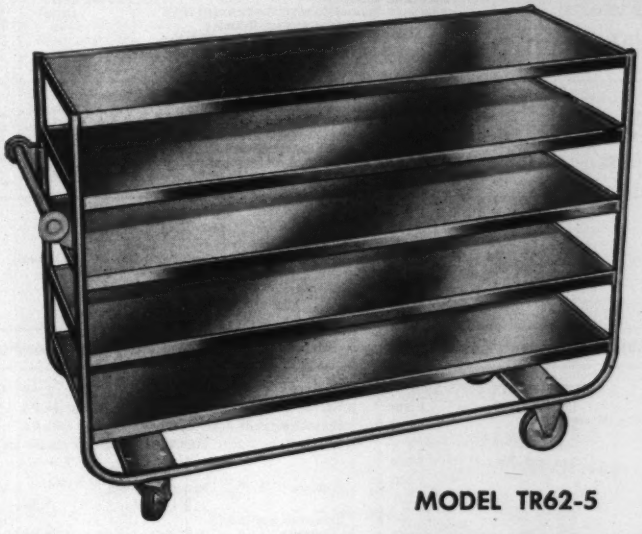

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	Model	Overall Length	Overall Width	Overall Height	Shelf Size	No. of Shelves	Shelf Clearance	Net Weight
Dish Truck	TR36-2	40⅞"	25"	37½"	23" x 36"	2	21½"	90 lb.
Dish Truck*	TR36-3	40⅞"	25"	37½"	23" x 36"	3	10"	100 lb.
Tray Truck	TR52-4	56⅜"	25"	49"	23" x 51½"	4	10"	136 lb.
Tray Truck	TR52-5	56⅜"	25"	49"	23" x 51½"	5	7¼"	158 lb.
Tray Truck	TR62-4	66⅞"	25"	49"	23" x 62"	4	10"	153 lb.
Tray Truck	TR62-5	66⅞"	25"	49"	23" x 62"	5	7⅛"	178 lb.

*Removable shelf

Note: For models with bumpers, there will be a change in width and length

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2nd WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Sister M. Inez, O.S.B., dietitian, Sacred Heart Hospital, Yankton, S. Dak.

	breakfast	noon	night
monday	Pineapple Juice **or** Applesauce Oatmeal **or** Puffed Rice Cereal Soft Cooked Egg	Minestrone Soup Vegetable Beef Stew (F) **or** Broiled Lamb Chop (S) Oven-Browned Potatoes (FS) Corn-on-the-Cob **or** Peas and Carrots (FS) Stuffed Prune Salad **or** Lettuce Wedge—French Dressing Rhubarb Crisp (F) **or** Baked Apple (S)	Cream of Pea Soup Broiled Beef Patty—Catsup (FS) **or** Broiled Bologna Stewed Potatoes (FS) Harvard Beets **or** Buttered Green Beans (FS) Asparagus Salad Banana Cream Pudding (FS) **or** Blue Plums
tuesday	Peach Nectar **or** Fresh Peach Farina **or** Wheat Squares Bacon Curls	Beef-Noodle Soup Roast Sirloin of Beef (FS) **or** Roast Loin of Pork Whipped Potatoes—Gravy (FS) Sauerkraut **or** Buttered Peas (FS) Citrus Fruit Salad **or** Relish Plate Lemon Meringue Pudding (FS) **or** Wedge of Cantaloupe	Fresh Vegetable Soup Chicken Salad Sandwich (F) **or** Creamed Chicken in Toast Cup (S) Potato Chips (F) Buttered Carrot Sticks **or** Spinach Souffle (FS) Perfection Salad **or** Spiced Apple with Celery Curls Gelatin Cubes (S) **or** Fresh Pear (F)
wednesday	Orange Juice **or** Stewed Prunes Farina **or** Puffed Wheat Cereal Poached Egg Sweet Roll	French Onion Soup—Cheese Sticks (F) **or** Broth (S) Ham Loaf with Mustard Sauce **or** Swiss Steak (FS) Creamed New Potatoes (FS) Buttered Succotash **or** Baked Zucchini Squash (FS) Sliced Tomato **or** Pear-Cheese Salad Fresh Peach Shortcake—Whipped Cream (F) **or** Vanilla Ice Cream (S)	Apple Juice Chop Suey on Chinese Noodles (F) **or** Roast Leg of Veal (S) Baked Potato (S) Peas in Cream (S) **or** Baby Lima Beans (F) Banana-Nut Salad **or** Lettuce Salad—Mayonnaise Butterscotch Pudding (FS) **or** Canned Apricots in Syrup
thursday	Half Grapefruit **or** Grapefruit Juice Rolled Wheat Cereal **or** Bran Flake Cereal Scrambled Eggs	Chicken-Rice Soup Chicken Fricassee (FS) **or** Baked Pork Steak O'Brien Potatoes (F) Broccoli—Hollandaise Sauce **or** Green Beans (FS) Pineapple-Date Salad **or** Fresh Fruit Salad Baking Powder Biscuit—Honey Jelly Roll with Whipped Cream (F) **or** Fresh Fruit Cup	Cream of Tomato Soup—Croutons Beef Biscuit Roll with Gravy **or** Ground Beef with Vegetables (FS) Mashed Potato (FS) Cauliflower **or** Stewed Tomatoes (FS) Sliced Tomato **or** Chef Salad—French Dressing Cottage Pudding with Apricot Squce (F) **or** Applesauce (S)
friday	Prune Juice **or** Sliced Banana Malt Meal Cereal **or** Cornflakes Soft Cooked Egg Raisin Bread Toast	Duchess Soup Halibut Steak—Egg Sauce (FS) **or** Meat Loaf—Tomato Sauce Scalloped Potatoes (FS) Glazed Parsnips **or** Buttered Beets (FS) Waldorf Salad **or** Celery and Carrot Sticks Cheese Cake (FS) **or** Lemon Sherbet	Cranberry Juice Cocktail Deviled Egg in Lettuce Cup **or** Macaroni and Cheese Casserole (FS) Chopped Spinach with Lemon (FS) **or** Wax Beans Tomato-Cucumber Salad **or** Garden Lettuce with Sour Cream Dressing Fresh Blue Plums—Gingersnaps (F) **or** Canned Peach (S)
saturday	Blended Juice **or** Kadota Figs Oatmeal **or** Ready-to-Eat Rice Cereal Bacon Coffee Bread	Pepperpot Soup Pot Roast of Beef (FS) **or** Chili Oven-Browned Potatoes (FS) Buttered Mixed Vegetables **or** Buttered Carrot Sticks (FS) Melon Ball Salad **or** Diced Fruit Salad Grapenut Custard (FS) **or** Bing Cherries in Syrup	Beef Soup Stuffed Green Pepper (FS) **or** Scrambled Eggs and Ham Buttered Rice (FS) Buttered Peas **or** Julienne Green Beans (FS) Head Lettuce Salad—Russian Dressing **or** Relish Plate (celery, pickles, radishes) Fruited Geltain with Whipped Cream (FS) **or** Sliced Orange
sunday	Grape Juice **or** Cantaloupe Wedge Farina **or** Shredded Wheat Cereal Scrambled Egg— Sausage Pattie	Chicken Broth with Noodles Fried Chicken (F) **or** Baked Chicken (S) Mashed Potatoes (FS)—Giblet Gravy Corn-on-the-Cob (F) **or** Buttered Green Peas (S) Lime Gelatin Salad **or** Cranberry Sauce Butterscotch Sundae (S) **or** Fresh Strawberries (F)	Lemonade Bacon, Lettuce and Tomato Sandwich (F) **or** Creamed Chipped Beef on Toast (S) Potato Chips (F) Buttered Asparagus Spears **or** Summer Squash (FS) Tangy Green Bean Salad **or** Fruit Salad Angel Food Cake (FS) **or** Fresh Peach

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverage are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	5 lbs.	
Chipped Beef, Dried	U. S. Good	1 lb.	
Ground Beef	U. S. Good, 5 lb. pkg.	70 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	35 lbs.	
Round (Bottom)	U. S. Standard	30 lbs.	
Steak, Swiss	U. S. Good, 4 oz. each	20 lbs.	80
Stew	U. S. Good	20 lbs.	80
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	15 lbs.	40
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Ham (Pullman)	Ready-to-eat	20 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	20
Sausage (Bulk)	Lean	10 lbs.	
Steaks (Boneless)	Grade A, 4 oz. each	10 lbs.	40
VEAL			
Chop Suey Meat	U. S. Good	15 lbs.	60
Leg (B.R.T.)	U. S. Good	7 lbs.	20
FISH			
Halibut	Steaks, 5 oz. each	25 lbs.	80
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	150 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	75 lbs.	

Item, Specifications, Amounts & No. of Servings		
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	25 lbs.
Cantaloupe	Crate, 45s	½ crate
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
Peaches	Basket, 20s	10 baskets
Pears	Box, 120s	½ box
Plums, Blue	Basket (5 x 5)	3 baskets
Strawberries	Quarts	12 qts.
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	9 stalks
Celery	White	1½ doz. stalks
Corn on the cob	Bag, 50s	2 bags
Cucumbers		6 lbs.
Endive	Curly	6 heads
Lettuce	Head, 48s	2 crates
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Parsley	Bunch	1 doz.
Parsnips		5 lbs.
Peppers, Green		15 lbs.
Potatoes, White	Bag No. 1	400 lbs.

Item, Specifications, Amounts & No. of Servings			
Radishes	Bunch	2 doz.	
Squash, Summer		20 lbs.	
Squash, Zucchini		25 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
FROZEN FRUITS			
Apricots	Halves, 8 lb. can, 5-1 sugar	8 lbs.	
Grapefruit and Orange Sections	8 lb. can	16 lbs.	
Melon Balls	8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Rhubarb	8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	27½ lbs.	165
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	10 lbs.	60
Beans, Wax	Cuts, 2½ lb. pkg.	2½ lbs.	15
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	20 lbs.	120
Peas and Carrots	2½ lb. pkg.	15 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	20 lbs.	120
Succotash	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

PLEASE CUT ALONG THIS LINE

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL

3rd WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Sister M. Inez, O.S.B., dietitian, Sacred Heart Hospital, Yankton, S. Dak.

PLEASE CUT ALONG THIS LINE

	breakfast	noon	night
monday	Orange Slices or Pineapple Juice Whole Wheat Cereal or Ready-to-Eat Wheat Flake Cereal Scrambled Eggs	Vegetable Soup Veal Steaks with Gravy (FS) or Pork Cutlet Paprika Potatoes (FS) Fresh Spinach—Lemon Wedge (FS) or Diced Buttered Beets Peach-Cheese Salad or Tossed Green Salad Apple Crisp (FS) or Bing Cherries in Syrup	Fruit Punch Ham Salad with Pickle Slices or Beef Stew (FS) Baked Potato (FS) Stewed Tomatoes (FS) or French Fried Egg Plant Tomato-Cucumber Salad—Oil and Vinegar Dressing (S) or Fruits-in-Season Salad Chocolate Brownie (F) or Apricots in Syrup (S)
tuesday	Applesauce or Orange Juice Malt Meal Cereal or Cornflakes Poached Egg	Alphabet Soup Roast Turkey (FS) or Swedish Meat Balls Whipped Potatoes—Gravy (FS) Glazed Carrots or Zucchini Squash (FS) Blushing Pear Salad or Spiced Apple Salad Rhubarb Cobbler (F) or Tapioca Cream with Whipped Cream (S)	Tomato Juice Cold Cuts—Potato Chips or Rice and Beef Casserole (FS) Buttered Peas (FS) or Asparagus Spears Lettuce Wedge—French Dressing or Melon Ball Salad Ice Cream (FS) or Fresh Peach
wednesday	Stewed Prunes or Apple Juice Oatmeal or Bran Flake Cereal Bacon Curls Blueberry Muffin	Cream of Celery Soup Roast Beef (FS) or Veal Birds with Gravy Creamed Potatoes (FS) Eggplant Baked in Tomato Sauce (FS) or Cream Style Corn Molded Fruit Salad or Stuffed Date Salad Pineapple Refrigerator Cake (F) or Baked Pear (S)	Orange Juice Chicken Pie with Biscuit Topping or Lamb Stew (FS) Buttered Noodles (FS) Diced Carrots and Peas or Green Bean (FS) Red-White Salad (tomato slice with chopped celery and mayonnaise) or Vegetable Salad Butterscotch Pudding—Crunch Topping (FS) or Fresh Fruit Cup
thursday	Sliced Banana or Orange Juice Farina or Rice Squares Soft-Cooked Egg Cinnamon Toast	Beef-Noodle Soup Cubed Steak (FS) or Spanish Pork Chop Mashed Potato (FS) Seven-Minute Cabbage or Buttered Spinach (FS) Chefs Salad or Waldorf Salad Orange Chiffon Cake (FS) or Watermelon Wedge	Chilled Cherry Juice Broiled Beef Patty (S) or Weiner in Bun; Catsup or Mustard (F) Baked Potato (S) Buttered Carrot Sticks or Buttered Asparagus Spears (FS) Kidney Bean Salad or Apricot-Pineapple Salad Baked Custard (FS) or Royal Anne Cherries in Syrup
friday	Cantaloupe Wedge or Pineapple Juice Rolled Wheat Cereal or Wheat Squares Poached Egg Sweet Roll	Shrimp Gumbo Haddock Fillets—Tartar Sauce (F) or Braised Chicken Livers on Rice (S) Delmonico Potatoes (F) Cauliflower and Peas or Buttered Beets (FS) Apricot-Date Salad or Lettuce Wedge—Mayonnaise Spice Cake—Caramel Icing or Peach Halves in Syrup	Blended Juice Salad Plate—Fresh Fruit, Cottage Cheese, Date-Nut Bread Sandwich (F) or Scrambled Egg on Toast Sandwich (S) Creole Celery or Summer Squash (FS) Orange Salad Lemon-Filled Sponge Cake Roll (FS) or Green Gage Plums in Syrup
saturday	Grapefruit and Orange Sections or Blended Juice Farina or Cornflakes Scrambled Eggs and Ham	Vegetable Beef Soup Braised Short Ribs (F) or Roast Leg of Veal (S) French Fried Potatoes or Buttered Potatoes (FS) Creamed Carrots (FS) or Mashed Turnips Relish Plate or Cabbage and Orange Salad Gelatin Cubes with Cream (S) or Fresh Fruit Cup (F)	Grape Punch Chicken and Rice Bake (S) or Salisbury Steak—Buttered Rice (F) Buttered Green Beans (FS) or Baby Lima Beans Peach Fan Salad or Carrot and Raisin Salad Chocolate Chip Cookies (F) or Pears in Syrup (S)
sunday	Sliced Peaches or Apricot Nectar Whole Wheat Cereal or Ready-to-Eat Oat Cereal Soft-Cooked Egg Sweet Roll	Chicken-Rice Soup Baked Ham with Raisin Sauce (F) or Broiled Chicken (S) Potatoes au Gratin (FS) Buttered Broccoli (F) or Buttered Wax Beans (S) Banana Salad or Spiced Sekel Pear Salad Apple Pie (F) or Ice Cream—Chocolate Topping (S)	Lemonade Salad Plate—Sliced Turkey, Potato Salad, Fresh Fruit (F) or Broiled Beef Patty (S) Baked Potato (S) Asparagus—Brown Butter (FS) or Buttered Peas Fruit Salad or Lettuce Wedge—French Dressing Chocolate Cake (F) or Canned Peaches in Syrup (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverage are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Frankfurters	All beef, 8-1 lb.	8 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	50 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	30 lbs.	
Short Ribs	U. S. Good	50 lbs.	
Steaks, Cubed	U. S. Choice, 4 oz. each	20 lbs.	80
Stew	U. S. Good	15 lbs.	60
LAMB			
Stew	U. S. Good	20 lbs.	60
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Chops, Loin	Grade A, 4 oz. each	10 lbs.	40
Ham (Pullman)	Ready-to-eat	55 lbs.	
Steaks (Bonless)	Grade A, 4 oz. each	10 lbs.	40
VEAL			
Leg (B.R.T.)	U. S. Good	20 lbs.	
Steaks, Club	U. S. Good, 5 oz. each	25 lbs.	80
FISH			
Haddock	Fillets, skinless, 4 oz. each	25 lbs.	100
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	40 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	100 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	12 lbs.	

Item, Specifications, Amounts & No. of Servings		
Livers, Chicken	1 lb. pkg.	5 lbs.
PREPARED MEATS		
Assorted Cold Cuts		5 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	60 lbs.
Cantaloupe	Crate, 45s	1 crate
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Melon, Honeydew	Crate, 9s	2 crates
Oranges	176s	1 box
Peaches	Basket, 20s	1 basket
Pears	Box, 120s	1 box
Watermelon	30-35 lb. av.	40 lbs.
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	3 stalks
Celery	White	6 stalks
Cucumbers		6 lbs.
Eggplant		10 only
Endive	Curly	6 heads
Lettuce	Head, 48s	2 crates
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.

Item, Specifications, Amounts & No. of Servings			
Parsley	Bunch	1 doz.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	2 doz.	
Squash, Summer		20 lbs.	
Squash, Zucchini		25 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Turnips, Yellow		5 lbs.	
FROZEN FRUITS			
Apples	Sliced, 8 lb. can, 5-1 sugar	48 lbs.	
Grapefruit and Orange Sections	8 lb. can	16 lbs.	
Melon Balls	8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Rhubarb	8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	22½ lbs.	135
Beans, Green	Cuts, 2½ lb. pkg.	20 lbs.	120
Beans, Lima	Small, green 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	2½ lbs.	15
Broccoli	Stems and buds 2½ lb. pkg.	15 lbs.	90
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	12½ lbs.	75
Peas and Carrots	2½ lb. pkg.	2½ lbs.	15
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180

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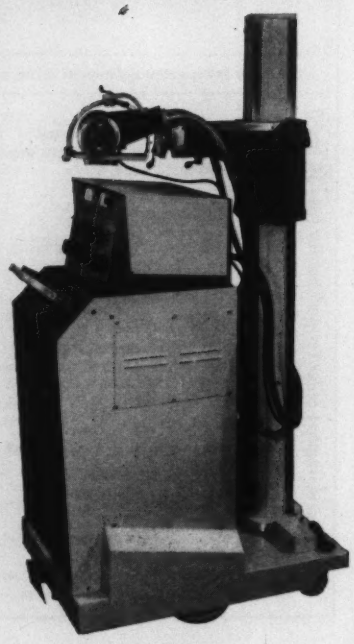
YOU CAN AVOID RETAKES IN MOBILE RADIOGRAPHY

New Westinghouse Newport 200 won't let you make a bad exposure!

Here's why—if exposure *is* attempted on a line where the kv drop is sufficient to reduce penetration to an unacceptable level, the new Westinghouse Expose-Sure circuit *rejects* the technique and lights a "no exposure" light.

Newport 200 is also current conscious! It automatically compensates via the timer for any change in milliamps—$\frac{1}{20}$ sec through 300 mas. For extra-fast timing, $\frac{1}{60}$ sec is available optionally.

For complete information, please contact your local Westinghouse X-ray salesman, or write Westinghouse Electric Corporation, X-ray Department, Section 380, 2519 Wilkens Avenue, Baltimore, Maryland. J-08380



YOU CAN BE SURE...IF IT'S **Westinghouse**

WATCH WESTINGHOUSE FOR NEW DEVELOPMENTS IN RADIOLOGICAL EQUIPMENT

COMBINATION washwheel and extractor (shown installed at Mountainside Hospital, Montclair, N.J.) makes double use of existing laundry space.

WHAT'S AHEAD IN HOSPITAL EQUIPMENT

THIS complex device is capable of completing many routine chemical analyses automatically, making possible significant savings in laboratory manhours. This machine is in use at Mountainside Hospital, Montclair, N.J.

by LAWSON A. MORGAN

Arresting new developments in many areas, including electronics and nuclear energy, will transform diagnostic and operative techniques as well as hospital procedures, according to the author. He discusses the great variety of new equipment and its implications for better patient care.

MUCH OF my information we obtained from persons who were familiar with research projects pertaining to our field of endeavor. Manufacturers were contacted and some information was obtained from them concerning new items that were in the process of manufacture. Some information was released on items actually on trial use in some few hospitals. Many of the following items and ideas are still on the drawing boards—many are still in the dream stage. Members of our medical staff gave me information on research being conducted by their colleagues.

Electronics and nuclear energy are two of the fields that will play a great part in the future developments of our hospital products and equipment. Electronic and nuclear devices have already proven their worth in industry.

Electronics will lead us into an era of doing more work with less manpower. In our limited ability to compete with industry for qualified manpower we are constantly faced with the problem of finding labor-saving devices to use in our hospitals, and are always seeking new and better diagnostic equipment, new and better operating equipment, new and better business office methods and equipment with which to make these methods more efficient. We also need new and better methods of operating our food services and of issuing supplies from our storerooms and central supply rooms.

EQUIPMENT FOR DIRECT CARE

One of our anesthesiologists can visualize the day when he can monitor, from a central control booth, the administration of anesthesia to three or four patients simultaneously. With the aid of a cardioscope, carbon dioxide analyzers, oxygen control valves, visual methods of observing the patients' color etc., this physician believes he can successfully administer these patients. In the advent of complications he merely leaves the control booth, makes necessary adjustments to the anesthesia apparatus and returns to this booth to observe the remainder of the procedures.

Electronic Organs—The most spectacular development in this area of electronics is electronic mechanisms acting as temporary substitute organs in the human body while the natural organ is being worked upon. That a man-made device could ever, however briefly, take over the functions of a bodily organ would have seemed wildy

Lawson A. Morgan is purchasing agent, Mountainside Hospital, Montclair, N.J.

This article is adapted from an address presented to the Institute on Hospital Purchasing, sponsored by the American Hospital Association, on Feb. 10, 1959 in New York City.

SINCE 1860

Nurses Station Equipment to Do You Have in Mind

Aloe-Exclusive Units Developed To Do A Specific Job Alone Or Coordinated In Assemblies Of Any Desired Size.

Whether you plan a Nurses Station to provide nursing service for a small number of beds or a large, busy division, Aloe has designed and manufactures equipment for the job.

Hospital Tested in Use

Aloe recognizes complete acceptance of any Aloe developed unit only after long use in a large cross section of the nation's hospitals. Each unit shown here is now in use in many of the world's leading hospitals, and is fully accepted as equipment designed and built according to the highest standards in the industry.

Aloe-Designed and Manufactured

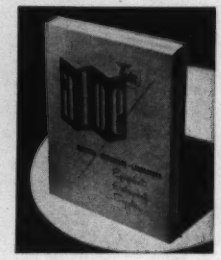
All the equipment shown here was originally designed and is manufactured in our own St. Louis factory. Experienced Aloe equipment engineers work closely with hospital authorities to develop specific units or coordinated assemblies to meet the exact requirements of the hospital user.

Functionally Interrelated Units

Aloe Nurses Station equipment has been designed to function in coordinated groups regardless of size of assembly. Time and labor is saved, permitting a greater volume of work to be accomplished in less space with minimum confusion.

Planning Service

Aloe Equipment Planning Service, staffed by experienced equipment specialists, is prepared to give you expert assistance in equipment layout and selection. Write or see your Aloe Representative for details.



You will find complete specifications of Aloe Nurses Station Equipment in our 804-page General Catalog No. 189. If this world's most complete catalog is not in your files, your Aloe Representative will be happy to supply you with a copy.

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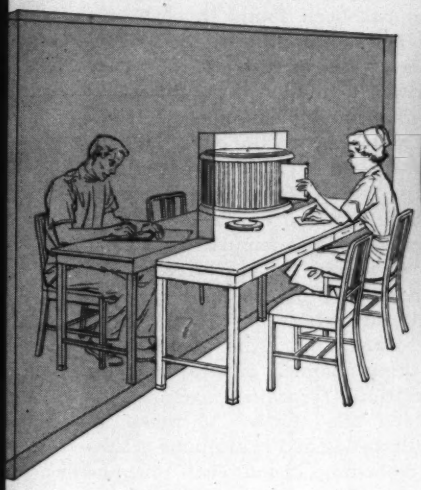
Multi-Service Storage-Sink unit with Narcotics Locker—a complete work center.

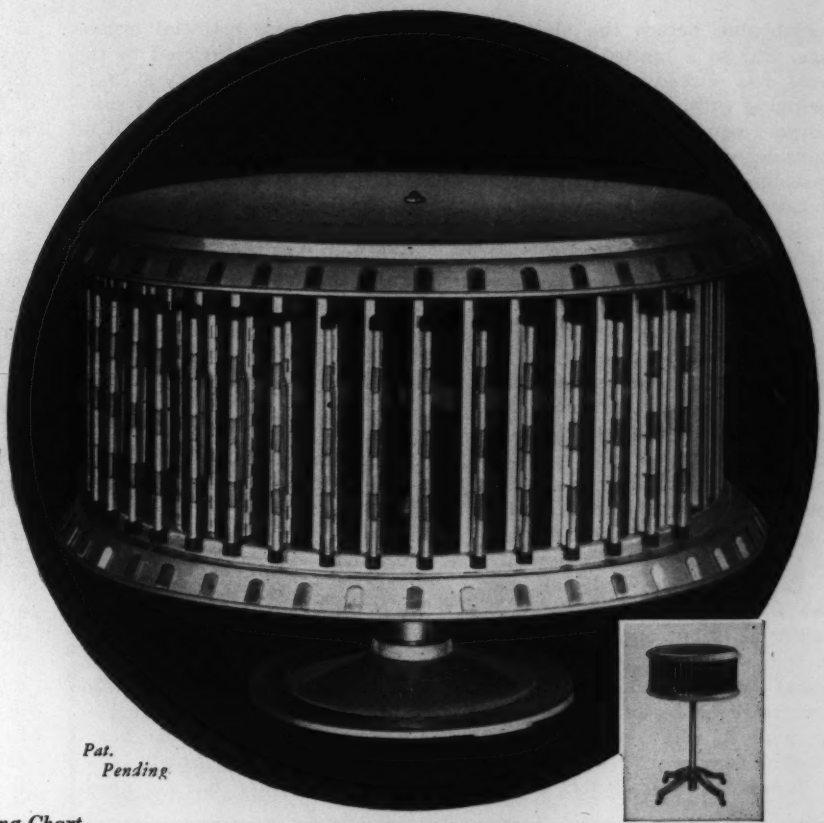
McGregor Chart Desk—combines desk with 20, 30 or 40 chart storage capacity.

Midget McGregor—saves space in close quarters—18-chart capacity.

Suggested assembly of modules: 15-chart units may be assembled in banks.

The Job

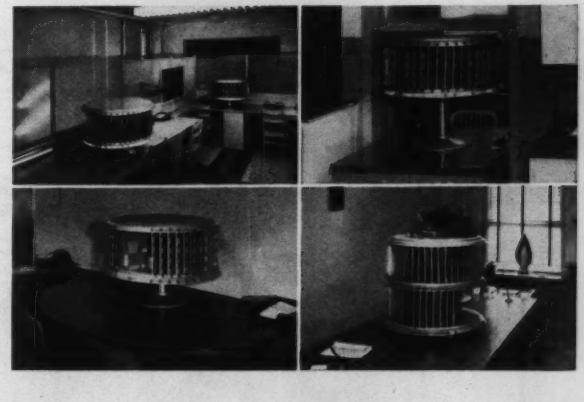


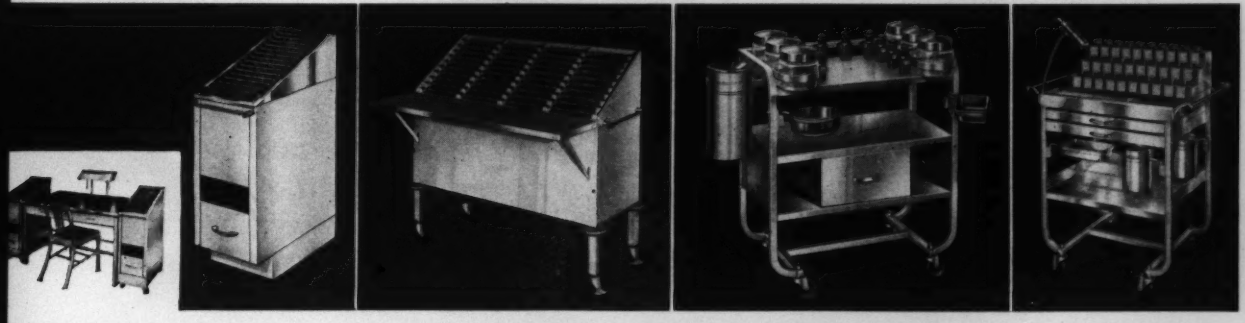


Pat. Pending

The Aloe-Exclusive Revolving Chart Holder (at right above) has gained tremendous popularity during the past decade. Reasons are obvious: unequalled convenience in actual use, and great variety of possible arrangements for convenience of access. Arrangement shown above (left) solves a common problem involving free access to the charts by both doctors and nurses without mutual interference. Counter model unit may be placed between areas divided by an actual partition or opposite seating. At right is shown a few of the many other possible arrangements of this versatile unit.

Available in 20, 30 and 40 chart capacities. Mobile unit also available (inset).





Mobile unit used alongside Nurses desk. Easy to modify or expand.

Mobile Chart File with folding work shelf; available 20, 30, or 40 chart capacity.

Alumiline Koenig Dressing Cart carries complete facilities for dressing service.

Alumiline Dispensa-Cart—a complete, one-trip medicine dispensing unit.

improbable before the electronic age. But to a limited extent this goal has already been reached, bringing within bounds of feasible surgery some operations formerly considered imprudent, if not impossible. The most dramatic of the substitute organs is the artificial heart. Here we have an electrically driven and electronically controlled device which by-passes blood flow around the heart and carries out the normal effects of a heart beat while maintaining pace adjusted to the needs of the patient. When one reflects that blood must not clot within the artificial heart, that temperatures and pressures must be maintained with utmost precision, it is clear that here we have a case where medical science is stranger than science-fiction.

Paralleling the artificial heart, we have the development of an artificial lung and an artificial kidney, each by-passing the natural organ while it is being examined or repaired, each made possible by electronic sensing and control devices.

Inevitably one wonders whether the use of these artificial organs need forever be restricted to the operating room. In theory at least, it is conceivable that one day compact electronic substitutes will be provided on a permanent basis to replace organs that have become defective through injury or age. Artificial kidneys, lungs and even hearts may then become as familiar as artificial teeth or hearing aids. Admittedly the idea is fantastic, but, as the marvels of electronics unfold, the line between fantasy and fact is ever harder to define.

DIAGNOSTIC EQUIPMENT

Radar and sonar, so vital to national security, have found valuable applications in diagnostic medicine. Sonic and ultrasonic vibrations are focused on the bodily area under examination. When they strike internal structures, they are absorbed or reflected. The reflections are systematically detected and the location of an obstruction exactly charted. Unlike x-rays, ultrasonic beams can detect cysts and growth which differ in structure, but not necessarily in density or effective atomic weight, from the surrounding mass.

Electronics is also of increasing importance to the radiologist. He has always contended with the risks of physiological damage where prolonged exposure is necessary. One solution of this problem has been found in electronic methods of amplifying the brightness of the picture, thereby permitting a smaller x-ray dosage. It is also proving possible electronically to sharpen the edges and the contrast in x-ray picturers and to improve stereoscopic pictures (those taken from a number of viewing angles simultaneously).

"Physiograph"—One large southern college of medicine has developed what is known as a "Physiograph." This apparatus is a three-channel, general purpose, electronic recording machine that allows the student to make simultaneous and continuous graphic recordings of four such variables as muscle contraction, respiratory capacity, blood pressure, and skin temperature as well as electroen-

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cephalograms and electrocardiogram readings. Such equipment enables the professors to have each student at his elbow during teaching and demonstration periods.

"Watchdog"—There have been demonstrations at many conventions of various types of electronic apparatus to give instantaneous blood pressure readings. Within the past year or so two New York anesthetists have perfected an electronic "Watchdog" that automatically determines the pulse and blood pressure at any given instant, or repeatedly at preset intervals. It is claimed that this can be used as a tourniquet in emergencies, and in surgery of the extremities, and its multiple pressure cuffs can be set to inflate and deflate alternately during treatment of pulmonary adema. It may also be of value in studying the pharmacological effects of drugs.

The following are new items, some of which are still in the research stage:

A cinephoto fluoroscope with an attached electrocardiographic scanner and electrolyte exchange director which helps to visualize for effective titrating of reactions to different cardiac stimulants and depressants.

A newly developed radiographic screen for deep, low voltage, direct vision fluoroscope observation of blood flowing through coronary and cerebral vessels with minute doses of radio-opaque substances injected into the peripheral venous system.

An automatic fluid and electrolyte balancing agent by the colorimetric or flame photometric application for use in shock states.

A cardiolyzer apparatus for completely splitting exact sound effects of the heart into component parts. This machine differs from the tape record in that it exchanges the sound effects into color waves flashed on a screen for immediate breakdown into components of pitch, volume, intensity and timed to the exact moments of opening and closing of the cardiac valves and the snap of the chordea tendinae and papillary muscles.

Radioactive material dissolved in a gas is now being used to locate certain heart defects. Detection, within a certain time, of the radioactive substance on the patient's breath after it had been injected into the heart, enables medical scientists to check for intracardiac shunts, more commonly known as holes in the walls, separating the chambers of the heart.

The National Heart Institute at Bethesda, Md., is also experimenting with the use of a tiny Geiger counter inside the heart to measure the radioactive substance and so gain information about intracardiac shunts. This counter, it is stated, is too sensitive to be trustworthy at this time.

RADIATION STERILIZATION

Present methods of sterilization, for example, the autoclave and chemical methods, are quite familiar to you.

Another new method of sterilization is coming about: sterilization by ionizing radiation. Ionizing radiation is not unfamiliar; the simplest and best known form of ionizing radiation is the x-ray. However, during the past decade

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pioneering parenterals for a quarter century

a new form of ionizing radiation has been exploited. This new radiation is from isotopes, such as Cobalt 60.

Cobalt 60 emits gamma rays, which are the more penetrating of the ionizing radiations. The Cobalt 60 emanation of gamma rays consists of two photons of energy 1.33 and 1.17 MEV in cascade. The penetrating powers of gamma radiation are great—3¾ inches of water or its equivalent in product density will absorb half of this energy. Therefore, hospital equipment such as instruments, bedpans, linens, mattresses and other materials are completely penetrated by Cobalt 60 radiation, and thereby sterilized internally.

Sterilization by radiation offers several advantages. Cobalt 60 radiation fulfills all the requirements of simplicity safety and security. Sterilization by radiation can be accomplished at room temperature, thereby allowing treatment of heat- or chemical-resistant materials. Also, it is a continuing process.

One large corporation is now conducting a very thorough research program to answer the two significant questions concerning sterilization by ionizing radiation: (1) What radiation dose is required for sterilization? and (2) what will the effects of these sterilizing doses be on the materials sterilized?

ADMINISTRATIVE AIDS

In hospitals where conveyor belts are used in their central food service an electronic system can be built whereby several employees can be eliminated from the payroll. In our hospital we presently employ six girls on the food line to place individual items on trays as they pass each girl's stations. I believe that a pencil sensitive type menu can be used with an electronic apparatus that would place on the trays individual items —such as salt, pepper, sugar packets, cream bottles, milk cartons, butter patties, salads, desserts and other items presently being placed by hand. After placing this menu in the data processing mechanism, the electronic system would automatically place these items on the trays. In my opinion four of the six girls could be eliminated. This would leave one girl to start the mechanism in motion, the other to check trays to ascertain that all items necessary are on the tray.

Such a system could also be set up in the central supply room for filling orders for nursing stations. It could also be considered for use in the general storerooms.

● Several types of automatic typewriters and accompanying equipment have been on the market for several years. Some hospitals have purchased this apparatus. The machines are set up in a central office where special repetitive letters and other materials are automatically typed from punch tapes. Public relations letters and credit letters are prepared from tapes that are punched in such a way that personalized information can be inserted where necessary without the letter appearing to be a form letter. In addition, these letters are well typed and without error.

This same type of equipment could be utilized to prepare payrolls and payroll checks more efficiently than most methods in use today. Purchase orders can also be typed on these machines.

● Traveling requisitions can be used with punch tape information contained on each—showing the name and address of vendors, product description, package unit and any other necessary information. The requisitioning activity merely requires filling in the amount requested for purchase and the date desired. This requisition is then placed in the automatic typewriter, with the typist typing in the date and amount requested. The machine then takes over the processing of the remaining data from the punch card. It is estimated that with this system in use the over-all time required for typing orders for my department can be accomplished in less than one hour each day.

Similar set-ups can be made to process data for admission records, post patient ledger cards, notify Blue Cross and other insurance companies of admissions, prepare Blue Cross billings, post charges and credits to ledger cards, supply the varied statistical data required by administration and to perform many other services which now require long tedious hours. Many hospitals utilize the services of two or more persons to type bills with the use of punch cards as many as three or four thousand bills can be prepared in less than a day.

● A talking typewriter will one day be on the market. This machine—when perfected—will type any message that is fed into it by oral transmission. One of the difficulties encountered in the perfection of this machine is the phonetics peculiar to locale and nationalities—the different inflection in voices does not lend itself to clear typing by the machine.

● A new and different type of combination wash wheel and extractor is now available. We now have four of these machines in operation and with the rearrangement of other equipment, we also have enough space to properly operate our laundry service. In addition we were able to reduce our laundry personnel. Several months ago we contracted to take over the laundry service of another hospital in our community that had previously contracted with an outside laundry to take care of their needs. Along with this, our operating expenses and the fixed costs for water, steam and laundry materials have been reduced as compared with previous years.

PHYSICAL MEDICINE

Physical medicine and rehabilitation centers in hospitals are now becoming a major necessity and much thought and consideration must be given to properly supply them with the types of supplies and equipment necessary to meet their requirements. Many of these items, with improvements and new suggested application, should be considered for future use.

One such item is a hypo-hyperthermia unit used to reduce body temperature to as low as 60°F. One of the primary uses of this apparatus is in surgery during cardiac and neurosurgical operations, and in orthopedic cases where amputations are indicated. In physical medicine this same apparatus can be used to lower the temperature of individual parts of the body where "cold therapy" is indicated or necessary. This apparatus can be used for the preservation of limbs for short or long periods of time. It has the unique power to

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General Electric's Regent freestanding "island" table and new overhead tube hanger — dramatically improved operating facilities for the diagnostic x-ray room

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Unobstructed tubes — easy passage all around . . . ideal for consultation viewing.

Draft-horse stamina — Regent is built to shoulder your heaviest x-ray schedules.

Table
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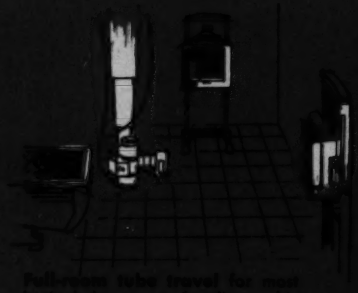


Full-room tube travel for most logical placement of radiographic apparatus.

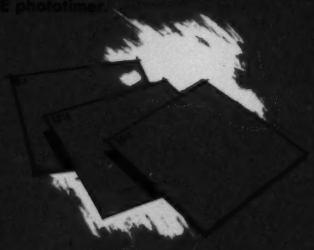
Here's important news for all who demand top-quality in heavy-duty diagnostic x-ray apparatus

General Electric Regent gives you more all-round value per dollar invested in an island-table installation

Counterbalanced x-ray tube positions at a touch — no complicated motor drive.

Roomy table top for patient comfort; simplifies positioning . . . reduces handling.

Super-Speed Reciprocmatic Bucky accepts interchangeable grids and G-E phototimer.



Bi-lateral tube hanger allows convenient cross-table radiography right from front of table . . . or rear, if desired.

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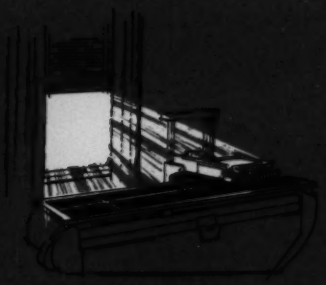
able tilts to 45° Trendelenburg – more than adequate for myelography, intravenous pyelography and gastro-intestinal studies.

Hydraulic angulation, fingertip controlled — response is fast, smooth and quiet.

Automatic spot-film unit — a sturdy "featherweight" to lessen fatigue in fluoroscopy.

NEW G-E bilateral tube hanger
adds another dimension to Regent radiography!



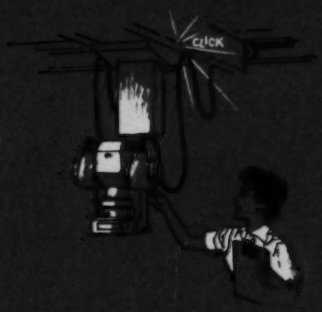
Spot-film phototimer has G-E sealed detector — unaffected by brightest room light.

Full-screen viewing — with primary rays automatically confined to fluoroscopic-screen area.

Fluoroscopic safety feature — panels close table slot when Bucky is parked at either end.

treme vertical range of tube nger makes low-angle position- easy.

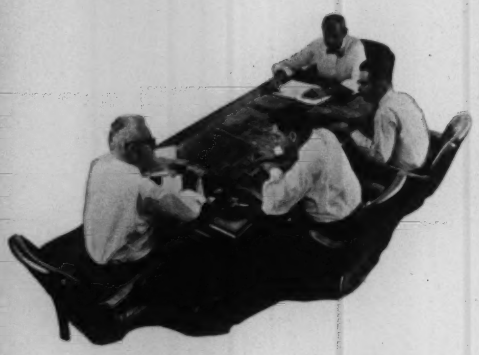
No tugging or fiddling to aim radiographic tube, thanks to full universal movement.



Click signal tells correct alignment when centering tube hanger to table's long axis.

General Electric offers you aid in

PLANNING THE HOSPITAL X-RAY DEPARTMENT



Planning and blueprinting a modern x-ray department are certain to involve the radiologist, the hospital administrator and the architect in a maze of complications. Logical starting point for any construction project involving x-ray facilities is your local General Electric x-ray consultant. Exploratory "shirt-sleeve" sessions with all persons involved first determine specific needs. Planning can then be expertly guided by our Installation Planning Service.

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Working with General Electric offers many plus values — extras that cost you nothing, yet count for so much. For one, installation planning — the ability to arrange your equipment for peak functional efficiency. Also nationwide facilities to bring you a complete line of supplies, repair and parts service whenever needed. Technical literature and consultation with skilled engineer-specialists to aid in resolving special x-ray problems.

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Below is the list of General Electric's cross-country sales offices. Call the one in your locale for complete information on the G-E Regent with new overhead tube hanger. Or write for information to X-Ray Dept., General Electric Company, Milwaukee 1, Wis., Room 1910.

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BALTIMORE 18, MD. - 3012 Greenmount Ave.
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BOSTON 35, MASS. - 1256 Soldier Field Rd.
BUFFALO 13, N.Y. - - - 960 Busti Ave.
BUTTE, MONT. - - 103 N. Wyoming St.
CHARLESTON 1, W. VA. - - - - - - - - - - 5616 MacCorkle Ave., S.E.
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DENVER 5, COLO. - - 3031 E. 40th Ave.
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DETROIT 19, MICH. - 18801 W. 7 Mile Rd.
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HARTFORD 5, CONN. - 528 Farmington Ave.
HONOLULU 1, T.H. - Fort and Queen Sts.
HOUSTON 1, TEX. - 1830 Westheimer Rd.
INDIANAPOLIS 7, IND. - 1845 W. 18th St.
JACKSONVILLE, FLA. - - 210 W. 8th St.
KANSAS CITY 6, MO. - 112 W. 19th St.
LITTLE ROCK, ARK. - - 3015 Lewis St.
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MILWAUKEE 3, WIS. - - 547 N. 16th St.
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PITTSBURGH 6, PA. - 231 S. Euclid Ave.
PORTLAND 10, ORE. - 522 N.W. 23rd Ave.
PROVIDENCE 9, R.I. - - 241 Harris Ave.
RICHMOND 21, VA. - 3425 W. Leigh St.
ROANOKE, VA. - 115 Albermarle St., S.E.
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CANADA

GENERAL ELECTRIC X-RAY CORPORATION, LTD.

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control simultaneously pain, shock, exudation, infection and tissue devitalization.

One manufacturer has developed an electronic thermometer that can be used with the above. As an electronic thermometer is placed in the esophagus the accompanying telemeter will register the exact body temperature more accurately than will other types of apparatus.

At times, especially in physical medicine, it is rather difficult to get some patients on the treatment table or bed. One item you should consider for the future is a tilt bed. This type of bed can be easily used to place a person in a standing position from a prone position, or from a prone position to a standing position, with a minimum of effort.

Another piece of apparatus to consider is the Electromyograph. Electromyography is to peripheral nerve injury as x-ray visualization is to bone fracture. This apparatus specifically detects, amplifies and converts muscle action potentials into visible audible waves by means of a cathode ray oscilloscope and loud speaker.

Late in 1957 an article appeared in a French journal concerning a tiny coil buried in the temporal muscle that directly excited the auditory nerve of a patient who had been totally deaf for a long time. After a period of time and many adjustments this patient could make out certain words and sounds. There appeared to be no tissue reaction from this buried coil.

Speech and hearing therapy units in rehabilitation centers will be a common area of research and treatment. There are many pieces of equipment being perfected for this area.

Automatic Analysis—One manufacturer is now making delivery on a system for automatic analytical chemistry. It operates without human supervision and with the highest degree of accuracy, dependability and reproducibility. The analyzer can do all this because it approaches the problem in a dramatically new way. It continuously measures and compares on a moving graph, the level of concentration of a given component in the test solution against a known concentration of that component in a standard control solution. No volumetric or gravimetric measurement is involved: rather it is a matter of continuous plotting of ratios (the concentration of sought material in the unknown against its known concentration—ratio in the standard control). On that account, it is never necessary to bring a reaction to completion.

Operation is completely automatic. Once the experiment is set up (which involves only hooking up a set of tubes and takes less than a minute) the samples to be analyzed are picked up, pumped along and mixed with a flowing stream of the diluent. The diluted sample then moves through a dialyzer where its diffusable constituents are separated and fed into a flowing reagent stream. This stream may now be passed through a variety of instruments, depending on the nature of the experiment. Some of these are: (1) a colorimeter for test involving color reaction; (2) a conductance bridge for determinations of pH and similar states; (3) a flame spectrophotometer for materials with characteristic burning wavelengths differential; and (4) a temperature-sensing element for analysis of gases.

In any case, the result is permanently recorded on a moving graph or printed directly on a read-out tape.

This apparatus is expensive, but the cost may be offset by the time element in payroll savings, or by the increased efficiency of the laboratory in obtaining more accurate test results in a shorter time.

Orthopedic News—Another product of the future is a substance that will replace some of the varied types of metallic and plastic bone plates, hip prostheses and other bone appliances now required to repair diseased and fractured bones. The articles currently in use are expensive and tedious operations are required to put them in place. At times the operations are unsuccessful because of the poor fit of the appliance being used—and also because of the extensive damage to the injured part. Research is being conducted with an osseous type solution or cement that can be used on fractures where open reductions are required. It is claimed that this material, when used with powdered "freeze dry" dehydrated bone, will cement the fractures when the fragments are approximated. A coating can also be applied to the outer portion of the bone which will harden in a short period of time. It is claimed this will make the repaired bone stronger than before and the patient will be able to use the affected part almost immediately—after the tissues have healed. A patient with a fractured leg should be able to walk normally.

Work is also being done on a cradle type counter-balanced rig that will, in many cases, eliminate the use of traction frames, cords and weights. With this type of rig, less time would be involved in rendering proper nursing and bed care.

Nuclear Power—Some time in the future, probably within our time, hospitals will more than likely plan nuclear power units to operate their plant. Even now, in some countries where natural resources are low, small nuclear plants are being built to take care of city and town needs. If this can be done for towns, why not hospitals?

The cost of building such a plant would be high, but, over a period of years, with the elimination of gas and electric bills and the thousands of dollars we pay for our fuel, and a reduction in employees, would we not save enough to pay for such a plant?

X-ray Developments—One manufacturer has recently announced a new x-ray film developing apparatus that will completely process an exposed film—develop, fix, rinse and be completely dry, ready for reading, in a matter of minutes.

Many of you are familiar with the fact that when installing an x-ray department, extra structural strengths must be added to withstand the extra load caused by the lead necessary to make the department safe. One large manufacturer of polyethylene plastics is experimenting with a plastic that will replace lead as a protective measure when x-ray machines are in use. If this is a successful venture, the impact it will have in reducing costs in future x-ray department

construction can readily be seen.

All of us have reason to delve into products of the future by assisting members of our staff—medical, office personnel and others. Recently, I was called in on an item that has long been needed in our operating room. During a certain type of operation it is necessary to remove the operating table pad from under the patient, an x-ray cassette is then placed in the proper position to take x-rays. This is always time consuming and requires extra personnel to remove the pad and then replace it. We are now having a pad made with a removable section that can be easily removed and replaced. This will be used to facilitate the technique of taking x-ray pictures during an operative cholangiography. During this operation and while the patient is open diodrast is injected and a picture is taken to reveal whether or not there are stones in the ducts.

Anti-Addiction—On many occasions narcotics or other types of strong sedatives are administrated for the relief of pain or discomfort. Many of these may become habit forming. Quite some time ago there was invented an inhalation type of apparatus—a face mask and a reservoir for holding an analgesic type of medication—to be used in cases where narcotics and other sedative type of medications were indicated. This mask is strapped to a patient's wrist, and when the analgesic is required, the patient merely places the mask over his face and takes a few deep breaths. Immediately when the drug takes effect the muscles relax and the hand falls away from the face, thereby removing the source of the medication. It is claimed that with the use of this apparatus many of the injectable narcotics and sedatives could be eliminated. Nurses would have more time to do other work and drug addiction would be reduced.

Plastic Mattresses—One manufacturer has been supplying several hospitals with sample materials made from plastic. From the hospitals using mattresses made from this material, varying reports are circulated as to its effectiveness. This mattress, it is claimed, can be washed, autoclaved and boiled. It is light in weight, averaging 18 to 20 pounds in weight as compared with the approximate 40-pound weight of the average innerspring mattress. When perfected and ready for general use, this mattress could do a great deal toward saving the cost of renovating mattresses now in use. Being light in weight, it could possibly save nursing time when turning mattresses, etc. It is claimed that this material is resistant to chemicals, mildew, odor retention, flames, and toxicity.

Another item offered by this firm is also in the experimental stage. It is a lightweight, washable blanket. This blanket, it is claimed, is as warm as wool, considerably lighter in weight, which would make it more comfortable to patients. It can be repeatedly washed with other linens without destroying its physical appearance. Incidentally, the general appearance of this blanket does not compare with the beauty of wool blankets. ■

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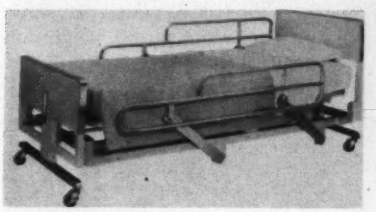
equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

Safety sides (10D-1)

Manufacturer's description: These new dual-purpose safety sides in fully raised position offer the utmost in patient protection. In the intermediate position, only the foot end is lower than the mattress surface, thereby affording the patient pro-



tection and at the same time allowing freedom of movement in and out of bed. Fully lowered, it permits quick and easy bed making. *Royal Metal Mfg. Co., Dept. H9, One Park Ave., New York, N.Y.*

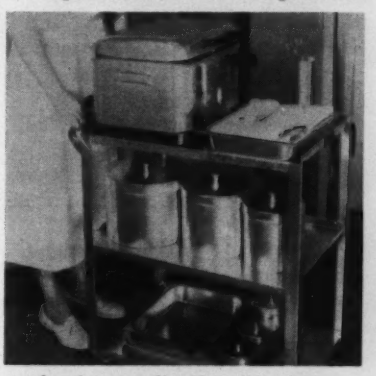
Graduated paper cup (10D-2)

Manufacturer's description: This new graduated paper cup provides a sanitary method of dispensing and

measuring doses of medicine. The cup is graduated in ounces and half-ounces, from one to six. The pure white paper cup is translucent for exact readings. *Sealright Co., Inc., Dept. H9, Fulton, N.Y.*

Compress heating unit (10D-3)

Manufacturer's description: This portable unit is a safe, convenient and sanitary method for preparing instantaneous hot packs, stupes and steam compresses. No preheating of compress solution is necessary. Moist pack is placed in unit, lever is depressed twice. Compress is



ready for application in six seconds. Compact in size, it can be placed on top of a cart and plugs into any standard 115-volt a.c. outlet. The non-pressure unit uses distilled water and requires no steam or water connection. *Wear-Ever Aluminum, Inc., Dept. H9, Wear-Ever Bldg., New Kensington, Pa.*

Dish trucks (10D-4)

Manufacturer's description: These new stainless steel dish trucks can be assembled in a few minutes following the simple illustrated instructions. There are three models; a small 2-shelf; a large 2-shelf; and a large 3-shelf. These units are fabricated from high quality stainless steel and mounted on casters with ball-bearing rubber-tired wheels. Available with continuous rubber bumpers if desired. These rugged units are economical, convenient to handle and store.

If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

- _____ Safety sides (10D-1)
- _____ Graduated paper cup (10D-2)
- _____ Compress heating unit (10D-3)
- _____ Dish trucks (10D-4)
- _____ Automatic ice cube maker (10D-5)
- _____ Baby restraint (10D-6)
- _____ Gamma globulin test (10D-7)
- _____ Refrigerator (10D-8)
- _____ Magnifier (10D-9)
- _____ By-pass valve (10D-10)
- _____ Food serving equipment (10D-11)
- _____ Linen service truck (10D-12)

PRODUCT LITERATURE

- _____ Brushes (10DL-1)
- _____ Engineered sanitation supplies (10DL-2)
- _____ Color coding (10DL-3)
- _____ Magnetic recording tape (10DL-4)
- _____ Detergents and equipment (10DL-5)
- _____ Diaper rash treatment (10DL-6)
- _____ Infection control (10DL-7)
- _____ Poison control (10DL-8)
- _____ Engineering (10DL-9)
- _____ Automatic boilers (10DL-10)
- _____ Operation and treatment methods (10DL-11)

NAME and TITLE _____

HOSPITAL _____

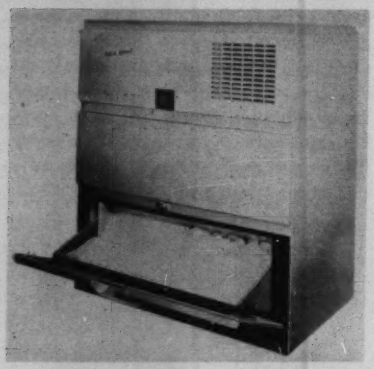
ADDRESS _____

(Please type or print in pencil)

Jarvis & Jarvis, Inc., Dept. H10, Palmer, Mass.

Automatic ice cube maker (10D-5)

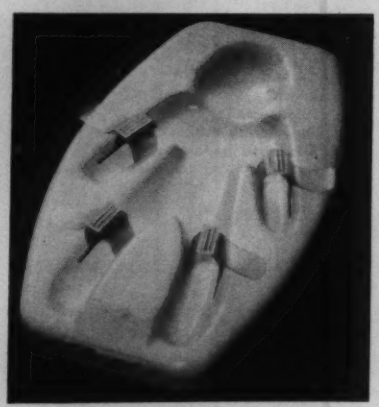
Manufacturer's description: This automatic crusher provides all crushed, all cubes; one half cubes, one half crushed; one-third cubes and two-thirds crushed; or one-third crushed and two-thirds cubes. An-



other setting on the machine supplies the crushed ice in large, coarse, medium, fine or extra-fine ice particles. There is a large divided bin and the unit shuts off automatically when either bin compartment is filled. A safety feature incorporated into the crusher prevents anyone from catching his hands in the crusher. *Kold-Draft Division, Uniflow Mfg. Co., Dept. H10, Erie, Pa.*

Baby restraint (10D-6)

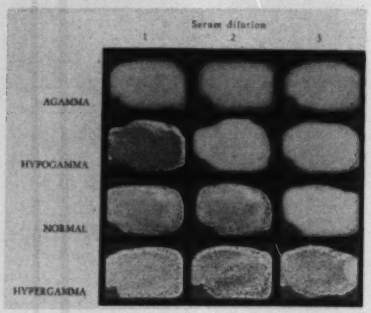
Manufacturer's description: New device is used for immobilizing infants during circumcisions, transfusions, x-rays and other procedures. It is molded of high-impact, nonporous plastic and has four adjustable plastic straps which fasten over an infant's limbs providing positive restraint of infants from 4½



to 16 lbs. It eliminates laundry by doing away with the need for diapers and towels ordinarily used. The raised platform between the legs provides a rest for clamp and other instruments. The smooth plastic surface can be wiped clean with ordinary disinfectants. *Olympic Surgical Co., Dept. H10, 1319 Second Ave., Seattle 1, Wash.*

Gamma globulin test (10D-7)

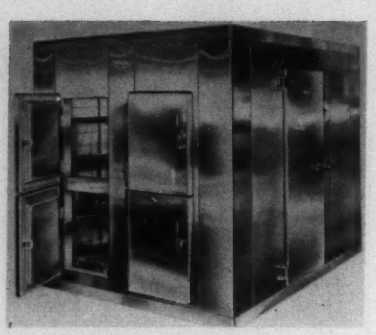
Manufacturer's description: GG-test, a new rapid slide test for estimating gamma globulin levels, based on a latex fixation reaction, is performed rapidly on a glass slide. It requires only one drop of a patient's serum. Test reactions, clearly visible in two minutes, indicate a normal level, a clinically significant low level, or an abnormally high level of serum gamma globulin in the patient's blood. A gammaglobulinemic serum produces no



reaction at all. Suspensions remain smooth in all three dilutions. Hypogammaglobulinemia produces clumping in the first dilution only. Serum with a normal amount of gamma globulin produces clumping in the first and second dilutions but not in the third. Clumping in all three dilutions indicates hypergammaglobulinemia. *Hyland Laboratories, Dept. H10, 4501 Colorado Boulevard, Los Angeles 39, Calif.*

Refrigerator (10D-8)

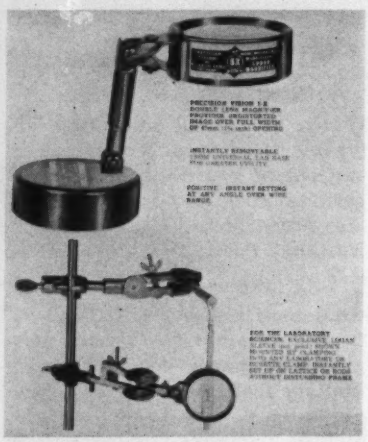
Manufacturer's description: New refrigerator is a combination reach-in, walk-in cooler, one area for standard reach-in service and the other for bulk storage. Two sliding doors separate the reach-in area from the walk-in area, permitting restocking of shelves from the rear and assuring proper rotation of products. Each compartment is equipped with an individual refrigeration system. Adjustable



shelving in both sections and floor drain and flanged sides allow complete washing down of the inside of the cooler. *Jordon Commercial Refrigerator Co., Dept. H9, 2200 Kennedy St., Philadelphia 37, Pa.*

Magnifier (10D-9)

Manufacturer's description: This new magnifier has high power, positive seating and instant removability helpful for examining instruments, scalpels, hypodermic needles and specimens too large for the microscope. Also helpful for examining foreign matter or par-



ticles in wounds, or in the eye, imbedded slivers for easier removal, and x-ray plates for obscure details. *S. B. Logan & Co., Dept. H10, 295 No. Mill St., Genoa City, Wis.*

By-pass valve (10D-10)

Manufacturer's description: This new all-brass by-pass valve simplifies water softener installations by eliminating the complex array of valves, unions, pipe nipples and tees formerly required in a conventional bypass installation. The new valve's tapered turn plug can direct the water flow either to the softener or directly into the water supply. It also can prevent a shut-

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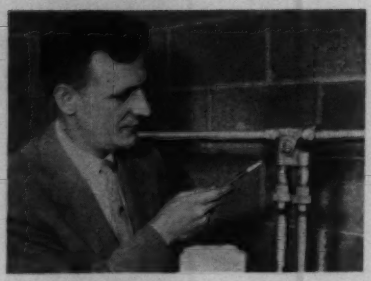

down of the entire water supply if the softener or water conditioner should require repairs. *Clayton Mark & Co., Dept. H9, 1900 Dempster St., Evanston, Ill.*

Food serving equipment (10D-11)
Manufacturer's description: This new vacuum bowl with dome cover is made of stainless steel for maximum sanitation as well as durability. It is part of a line of new

cooking utensils, table service, commissary items, kettles and sinks. *Legion Utensils Co., Inc., Dept. H9, 21-07 40th Ave., Long Island City, N.Y.*

Linen service truck (10D-12)
Manufacturer's description: This new linen service truck has movable hooks for bags that eliminate stretching bags to fit hooks. Truck has all-steel construction with 10-in. ball-bearing semipneumatic wheels on front and 5-in. swivel casters with rubber tread on the back for maneuverability. Short

canvas bag on one end and long white bag on the other. The truck is finished in green. *Lexco Engineering & Mfg. Corp., Dept. H9, 20 West Chestnut St., Souderton, Pa.*

product literature

SEE COUPON, PAGE 95

Brushes (10DL-1)—Brush catalogue contains over 40 pages of brush illustrations and descriptive text. It offers a simple recognition and ordering system. *Braun Brush Co., Dept. HL10, 8833 78th St., Woodhaven 21, N.Y.*

Engineered sanitation supplies (10DL-2)—New sanitation and building maintenance catalogue shows new disinfectants and deodorants, safer, more powerful insecticides and pest control products, new fast-acting cleaners and detergents for every purpose, plus many more products. *Geo. B. Robbins Disinfectant Co., Dept. HL10, Cambridge, Mass.*

Color coding (10DL-3)—Booklet explaining the basis of product color coding by marking certain sizes or types of product with a different color. Also explains how color is the element of composition that the human eye picks out and identifies first. *Becton, Dickinson and Co., Dept. HL10, Rutherford, N.J.*

Magnetic recording tape (10DL-4)—New brochure on the advantages of using magnetic recording tape as a dictating medium. Also explains the economy of tape, erasability, fidelity, and the electronic correction of errors directly on the medium. *DeJur-Amsco Corp., Dept. HL10, Business Equipment Division, 45-01 Northern Boulevard, Long Island City 1, N.Y.*

Detergents and equipment (10DL-5)—New sectionalized loose-leaf type catalogue giving comprehensive purchasing files of detergents, sanitizers, methods and application equipment. *Klenzade Products, Inc., Dept. HL10, Beloit, Wis.*

Diaper rash treatment (10DL-6)—New chart on diapering and the prevention and treatment of diaper rash. For nurses who instruct baby care courses as a visual aid to teach young mothers. *Chesebrough-Pond's Inc., Dept. HL10 485 Lexington Ave., New York 17, N.Y.*

Infection control (10DL-7)—Material on a quick antibacterial diagnostic test which is of great value in hospital infection control. Enables the physician to determine which antibacterial agent is most useful in the treatment of particular infection. *Media, Inc., Dept. HL10, 89 Lincoln Park, Newark 2, N.J.*

Poison control (10DL-8)—A new booklet to aid poison control centers in supplying physicians and hospitals with authoritative information on the symptoms and treatment of overdosage with newer pharmaceutical products. *Abbott Laboratories, Dept. HL10, North Chicago, Ill.*

Engineering (10DL-9)—New bulletin on handling heat transfer by radiation, conduction and convection. Also covered are the problems involved in the transmission of heat from a hot gas through a metal surface into water. *Sellers Engineering Co. Dept. HL10, 4876 N. Clark St., Chicago 40, Ill.*

Automatic boilers (10DL-10)—New bulletin on a new line of mechanical pressure atomizing oil-fired and partial pre-mixing gas-fired packaged automatic boilers. *Orr & Sembower, Inc., Dept. HL10, Morgantown Rd., Reading, Pa.*

Operation and treatment methods (10DL-11)—Material describing a new modality for arterial disease. Gives methods of positioning, application and operating the machine. *Poor & Logan, Mfg. Co., Dept. HL10, 7319 Varna Ave., No. Hollywood, Calif.*

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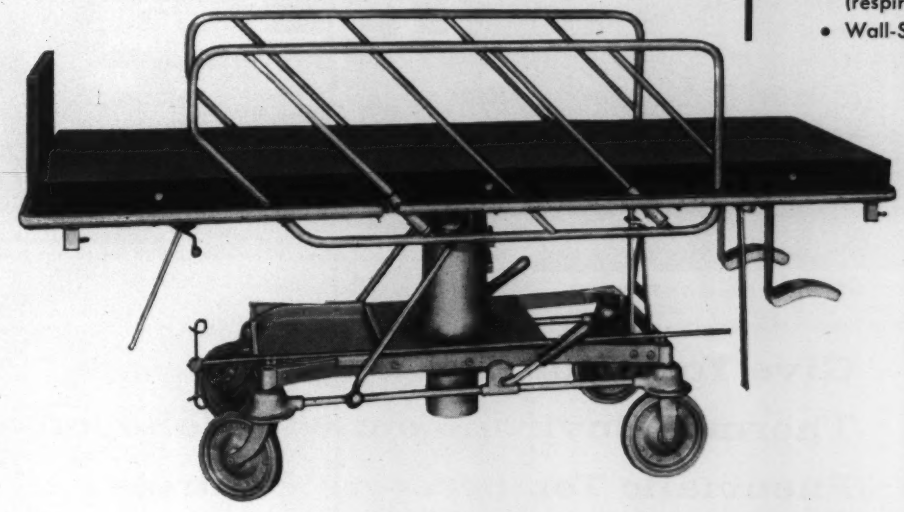

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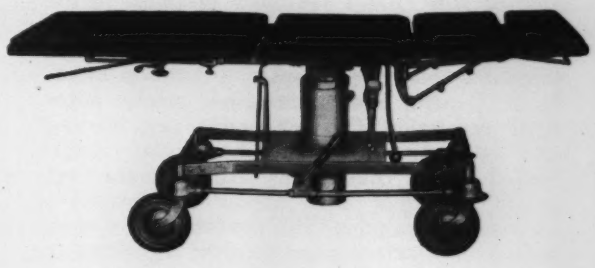

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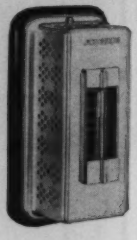

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SPRINKLER SYSTEMS FOR HOSPITALS

by W. J. VAN METER

Part 2: Choose the right system—then protect it

A SPRINKLER system in this hospital linen supply room guarantees that a fire starting in any of the wood, paper or cotton materials will be put out before it can spread to other areas of the hospital.

EACH hospital sprinkler system is "tailor-made". The sprinkler heads in this supply room, full of combustible materials, are located so that no objects can deflect their spray.

In Part II of this two-part article on the life-saving value of automatic sprinkler systems, the author explains the mechanical aspects of the different sprinkler systems, describes their operation and suggests how to maintain them at peak effectiveness.

Part I of this article, which appeared in the May 1 issue of this Journal, outlined the history and value of spinkler systems, explained their relation to patient and personnel safety and to insurance savings and discussed cost of installation.

AT THE outset, the author wishes to emphasize the fact that the design, installation and certification of sprinkler systems, in general and in detail, should be approved by the hospital's insurors so that the owner may enjoy all the benefits of this protection. The points developed in this article are primarily intended to stimulate interest in the subject of sprinkler systems for hospitals. Recognized automatic sprinkler contractors should be consulted when a decision is made to plan or consider sprinkler installation. These contractors are thoroughly informed of installation rules and requirements. Each building into which a system is installed is unique, and the system must be "tailor made" to its needs.

Hospitals may, within their particular requirements, be partially or completely sprinklered according to their features of construction and other considerations. However, in view of the perfect safety-to-life record shown in the fire history of completely sprinklered hospitals, it is well to give serious thought to complete sprinkler protection for the entire institution. There exists no better guarantee that loss of life by fire will never occur.

Although there are special types of sprinkler systems which may occasionally be encountered, the overwhelming majority of systems found in hospitals will be those designed for the automatic release of a water spray in a threatened area. The spray will be initiated by a local temperature rise above

W. J. Van Meter is a registered professional engineer in Santa Fe, N.M. He is a member of the Committee on Engineering and Maintenance, A.H.A.

a value predetermined in the manufacture, and the spray will continue until the water is manually shut off, or until the water supply is exhausted.

The best designed and installed sprinkler system in the world will afford poor protection if it is not served by a proper water supply. When public mains of adequate pressure, capacity and history of reliability are not available, elevated tanks having acceptable heads and capacities are generally the best alternative. For large installations, secondary sources of supply are considered necessary. These may be pumped from low pressure sources, or may come from other systems of mains of satisfactory pressure and capacity.

The heart and essence of an automatic sprinkler system is the sprinkler head. This unit appears in a number of designs; there are different type units for various applications, and details of design for the same type of service differ from manufacturer to manufacturer. They are all essentially alike in function and, superficially at least, they are all quite similar in appearance.

A sprinkler head may be thought of as a nozzle-like valve, usually located near the ceiling, either at the terminus of a branch line, or as a fitting superimposed on a run of pipe. In this respect, sprinkler heads are disposed on the sprinkler piping system in much the same manner as cocoa pods on the cocoa tree—some appearing at twig ends, and others growing abruptly from the bark of the tree's main branches.

The sprinkler system is so laid out that each sprinkler head "guards" a maximum of 200 square feet of floor area in light hazard occupancies (this category includes hospitals). The exact spacing and arrangement of sprinkler heads in a given area depend on numerous factors including occupancy, arrangement and spacing of structural members, area dimensions and resistivity of construction materials.*

*A complete digest of spacing and arrangement requirements as well as other pertinent considerations governing the design of sprinkler systems is contained in NFBU 13, a publication of the National Board of Fire Underwriters entitled, *Standards . . . for the Installation of Sprinkler Systems.*

The orifice in the sprinkler head (the usual orifice diameter is approximately one-half inch) is closed by a metal plug. A low melting-point alloy link holds the plug firmly on the orifice seat against the pressure within the system. The melting point of the restraining link for a particular sprinkler head may be selected from standard types varying from 135°F. to 500°F. according to the temperatures expected to be experienced at that location. When local temperature becomes high enough to melt the restraining link, the plug is ejected by the pressure within the system and a stream of water is discharged through the orifice. This stream is broken up into a spray by the deflector plate, which is integral with the sprinkler head. The proportions of upward and downward deflected spray vary according to the type of head. The amount of water discharged in gallons per minute is approximately 5.7 times the square root of the pressure in pounds per square inch. The fire extinguishing spray continues as long as the head is supplied with water, and no other head in the system will go into action until its own fusible link has been melted by excessive local temperature.

TYPES OF SPRINKLER SYSTEMS

Automatic sprinkler systems are divided into two main classes—the wet-pipe systems and the dry-pipe systems. Of the two, the first is probably the more common. A wet-pipe system normally carries water under pressure right up to the sprinkler heads. A dry-pipe system is installed when the possibility of freezing temperatures in protected areas, or in spaces traversed by the system piping, makes a wet-pipe system unacceptable.

The dry-pipe system carries air under pressure (usually at about 35 pounds per square inch) into that part of the system beyond a dry-pipe valve, which must be located in an area protected from freezing. Water under pressure is carried to one side of this differential type valve, while the air in the dry-pipe system exerts its pressure on the other side of the valve clapper. A variation of the dry-pipe valve is the mechanical type in which air pressure acts on the water clapper through a system of levers that multiplies the restraining force of a relatively small air clapper. When a sprinkler head link of a dry-pipe system fuses, the head opens and the air pressure in the system drops. The water pressure at the dry-pipe valves quickly overcomes the falling air pressure, forcing the water clapper open so that water is admitted into the dry-pipe system and discharges through the open head.

Other things being equal, a dry-pipe system is a more expensive installation than a wet-pipe system. The dry-pipe valve and the compressed air supply for maintaining pressure on the dry side are the principal contributors to the cost differential. Maintenance of a dry-pipe system is more time-consuming, hence more expensive. If only a few "dry heads" are required, it is sometimes feasible to plan for a wet-pipe system in which the small unheated area is protected by one of the following methods, listed in order of preference:

1. Provide sufficient heat in the area to prevent freezing.
2. Connect to an existing dry-pipe system.
3. Install small dry-pipe valves.
4. Use a nonfreezing solution in that part of the system.

In the case of No. 4 above, a U-loop within the heated area should be installed to prevent diffusion of water into the unheated area. All necessary valves and fittings for testing and filling with the nonfreezing solution should also be installed in the heated area.

Drainage—Properly designed sprinkler systems include adequate provision for drainage so that the entire system can be cleared of water when it becomes necessary. This is a fundamental requirement, and it is particularly important in dry-pipe systems. After use in a fire, a dry-pipe system must be completely drained and recharged with air before water is admitted to the dry-pipe valve. Wet-pipe systems require complete drainage if temporary suspension of heat to protected areas exposes any part of the system to freezing temperatures.

Air Pressure—Dry-pipe systems must have a convenient source of compressed air available for keeping up the pressure on the dry side. This pressure should be maintained at from 15 to 20 pounds per square inch above the normal tripping pressure of the dry-pipe valve. The permitted rate of air leakage from the system should be such that pumping of the system oftener than once a week is avoided. Air pressure in the system should be checked daily. The pumping should always be a manually controlled operation, as automatic means for maintaining system air pressure would defeat the purpose.

Single Purpose Use—Connections to the sprinkler system for domestic use or for any purpose other than fire protection should not be made. Circulation of water through the system is not normally desirable. Tuberculation and the introduction of sand, gravel and sediment may obstruct piping and interfere with the functioning of system components. A quiescent system, initially flushed and cleaned, is less prone to these disturbances than is one in which there is circulation.

Water Flow Alarms—Sprinkler alarms are devices so connected and installed that any flow of water through the system equal to or greater than that from a single opened sprinkler head will result in a signal that will indicate the occurrence of fire or the flow of water from the system. Alarms are desirable as announcers of fires and as indicators of water flow through broken or frost-ruptured system components into areas where serious water damage might be sustained.

Changes in Building Structure—Sprinkler heads must be located so that their sprays will not be rendered ineffective by either permanent or temporary obstructions. The original design of the system will provide for adequate spray coverage of all protected areas. Hospital personnel must be alert to prevent subsequent structural alterations (such as added partitions), installation of fixtures and equipment, and build-up of stored items from rendering the original installation ineffective in particular areas. Further, modifications in equipment or operations in a specific area which may cause significant changes in anticipated maximum temperatures may require a change in certain sprinkler heads to those of a more suitable temperature rating.

Any changes in occupancy or structure appreciably affecting sprinkler protection should be discussed with insurance representatives at the earliest opportunity not only to assure maximum fundamental protection but to make certain that the terms of the insurance agreement are not violated by the owner's acts.

SYSTEM FAILURES

Sprinkler system failures, as noted in Part I of this article, are almost always due to causes outside the systems themselves. Human errors are responsible for many of such failures, and these are often errors which impair the water supply to the system. Valves in sprinkler systems are kept to a minimum for this reason, but a certain number of valves is required as a practical necessity. When essential valves normally required to be open are found to be closed either through carelessness, ignorance or vandalism, protection is jeopardized. For this reason, regular recorded inspections of all valves in the system are regarded as a fundamental practice. An inspection interval of no greater than one week is considered necessary. If repairs or alterations to the system or structure require suspension of the water supply to an appreciable number of sprinkler heads for more than a few hours, temporary water supply or continuous patrolling of temporarily unprotected areas should be arranged.

INSPECTIONS

Once installed, tested and certified as satisfactory, hospital personnel must maintain the sprinkler system in an acceptable condition if its full value is to be enjoyed. This requires periodic inspection of all valves and pressure gauges, and the testing of the functioning components such as alarms and dry-pipe valves. Inspections of the entire system will be required to make sure that stored materials do not seriously obstruct the spray patterns of the sprinkler heads, that sprinkler piping is not being used as a convenient support for other pipe, structure or equipment and that paint or other material does not foul sprinkler heads.

Sprinkler heads in clean locations that are not exposed for long periods to temperatures near their fusing points can be expected to give good protection indefinitely. However, after they have been in service for around 15 years they should be critically examined for signs of incipient failure. Excessive heating, exposure to subfreezing temperatures, corrosive atmosphere, deposits of paint or other material, and mechanical injury all may affect a sprinkler head's operability, making it prone to open without experiencing a properly elevated temperature or rendering it inoperable under fire conditions. Heads having any parts deformed, coated, corroded, cracked or otherwise presenting a questionable appearance should be replaced, or representative heads should be removed and tested.

The sprinkler system in a hospital is a living installation which must continuously receive intelligent attention. External conditions brought on by natural processes or by human failure may impair it in its primary function—that of saving life and property by constantly fighting incipient conflagrations. Properly maintained, a well designed and carefully installed automatic sprinkler system is the best means man has devised for this purpose. ■

Sources of Information

The following sources can supply publications well worth studying:

A. *National Fire Protection Association*
60 Batterymarch Street
Boston 10, Massachusetts

B. *National Board of Fire Underwriters*
85 John Street
New York 38, N. Y.

C. *National Automatic Sprinkler & Fire Control Ass'n.*
60 East Forty Second Street
New York 17, N. Y.

D. *Factory Mutual Engineering Division*
184 High Street
Boston 10, Massachusetts

The author wishes to thank the National Fire Protection Association, the National Board of Fire Underwriters, the National Automatic Sprinkler and Fire Control Association and the Factory Mutual Engineering Division for making available literature used in the preparation of this article, and also extends his thanks to the following sprinkler manufacturers for suggestions and literature: The Grinnell Company, Automatic Sprinkler Corp. of America, Central Automatic Sprinkler Company, Globe Automatic Sprinkler Company, and Rockwood Sprinkler Company; and to Mr. Paul Johnson of the Blackstone Mutual Insurance Company of Providence, R.I.

Medical events record

also:
Volunteer program guide

LIFETIME HEALTH RECORD. David D. Rutstein. Cambridge, Mass., Harvard University Press, 1958. 127 pp. $2.25.

This publication successfully incorporates in a single volume both instruction in, and space for, recording the medical events of a lifetime.

In past generations when our medical history remained in the hands and the heads of a few physicians within a limited radius, need for such a volume might have been questionable. Increased medical knowledge, greater life span and, most important, the migratory nature of our lives today make it important that we record in some readily available place a history of our immunizations, illnesses and surgery. This book makes such a record possible. It begins with a note to the physician. Then, following a table of contents and general instructions, the book contains pages for entry of important information from birth record and family history up to (but not including) record of final illness and post mortem findings.

Dr. Rutstein has ably adapted the hospital medical chart summary, the pediatrician's record and the health record used in the armed forces into a book which is the first of its type developed for lay use. There is space, preceded by sound general instructions, for entry of all presently known important data together with provision for future entry of such information as immunizations as yet undiscovered. Because of the format, a patient recovering from one illness would find it necessary to record various aspects of that illness in several different places, i.e., hospital admissions, blood transfusions received, electrocardiograms and operations are all on separate pages. It is difficult to see how this disadvantage could have been circumvented.

This slender volume is printed on excellent stock and well bound as befits a book intended to last a lifetime. If one wonders whether such a record, with so much space where the purchaser becomes the author as he completes various entries, is overly expensive, perhaps he should calculate the cost at three cents a year rather than $2.25 per copy.

For one with the interest to keep it current, a book such as this can be of great importance. Like a life insurance policy, its greatest value accrues only when it is kept up to date. At least such a book is of some value; at most it could be lifesaving.—T. STEWART HAMILTON, M.D., *executive director, Hartford (Conn.) Hospital.*

Volunteer program guide

ORGANIZATION OF A DEPARTMENT OF VOLUNTEER SERVICE IN HOSPITALS. United Hospital Fund of New York. New York, The Fund, 1958. 52 pp. $1.10.

Any resemblance between volunteers and "the man who came to dinner" is superficial. Invited to help hard-pressed hospitals during World War II, volunteers came and stayed, not by accident but by design. Both volunteers and hospitals were experimenting. The fact that well organized volunteer departments are increasing is a tribute to their demonstrated value.

Mistakes were made, but there should be fewer in the future with the publication of this guide by the United Hospital Fund. More than any other single publication, it covers the essential elements of a hospital volunteer program, from the moment when the need for one is first recognized, through planning, operation and final evaluation.

Naturally, some of the guide's recommendations must be adapted to the needs of individual hospitals, but it is hard to believe there is a director of volunteers, no matter how experienced, who could not benefit from a careful reading of it. And a volunteer director, whose administrator and chairman of volunteers have been exposed to it, is doubly fortunate.

Although excellently balanced, I believe this guide is misleading on two counts. Under the subhead, "The Director of Volunteer Service" (p. 13), the guide states: the director's "*primary* responsibilities should be to work with and enable the Chairman of Volunteers to do the best job possible of interpreting the . . . program . . . to the Auxiliary". The primary responsibility of a director might be viewed differently by an administrator, who knows that nothing is more important than patient care, (that volunteers are present to enrich that care) and that the director is there to implement that purpose.

Under the subhead, "Recognition" (p. 35), in discussing the basis for a volunteer awards system, the guide indicates the usual requirement for such awards to be hours worked, but continues: "(Some hospitals) find it more practical to recognize years rather than hours of service". Years of what caliber of service? Years of, perhaps, helping once each twelve months with a campaign for funds? Common sense indicates the necessity for qualifying a "year" of service, which brings us right back to hours. The National Association of Volunteer Bureaus recommends that a year consists of at least 100 hours of service by daytime volunteers and 50 hours by those who serve in the evening. The American Red Cross and the Travelers' Aid Society, agencies using large numbers of volunteers, have found hours to be the fairest basis for awards.

The recommended reading list in the guide is excellent, as are the discussion of the role of the chairman of the committee on volunteer service and the final chapter on "The Volunteer of the Future". —ILDRA J. LARSON, *director of volunteers, Grant Hospital of Chicago, Inc.*

6 MINUTES...

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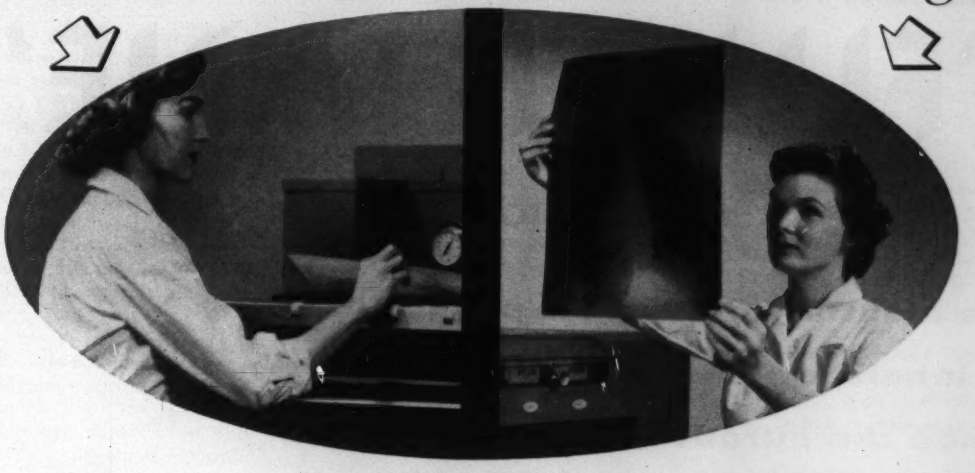

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personnel changes

● **Lewis G. Beardsley, M.D.** (see Pugh item).

● **Robert F. Bilstein** has been appointed assistant administrator of Sewickley (Pa.) Valley Hospital. He previously served as business manager of the Lutheran Tuberculosis Sanatorium, Denver; administrator of Graham Hospital, Keokuk, Iowa; administrator of Bismarck (N. Dak.) Hospital; administrator of Provident Hospital, Lincoln, Nebr., and Lutheran Hospital, Beatrice, Nebr.

● **Douglas R. Brown** has been appointed assistant administrator of Binghamton (N.Y.) City Hospital. He was formerly director of the Albany (N.Y.) Medical Center Clinics. Mr. Brown is a graduate of the Columbia University program in hospital administration.

● **Manuel Cohen** has been appointed executive director of the Jewish Hospital of Hope, Montreal, Quebec, Canada. He was formerly assitant director of Montefiore Hospital, New York City. Mr. Cohen is a graduate of the Yale University program in hospital administration.

● **James W. Cooke** has been appointed administrator of Lynn Hospital, Lincoln Park, Mich. He was formerly assistant director of Akron (Ohio) City Hospital. Mr. Cooke is a graduate of the Northwestern University program in hospital administration.

● **James W. Crary** has been appointed executive director of Community Hospital, Almont, Mich. He was formerly assistant administrator of Saginaw (Mich.) General Hospital. Mr. Crary is a graduate of the Northwestern University program in hospital administration.

● **Capt. Gerard B. Creagh** (see Kline item).

● **Robert C. Gillespie** has been appointed lay assistant administrator of St. Anthony Hospital, Columbus, Ohio. He succeeds **J. David Luckhaupt,** who has accepted a similar position at St. Michael's Hospital, Newark, N.J. Mr. Gillespie is a graduate of the Northwestern University program in hospital administration.

● **Normand E. Girard** has been appointed executive assistant for professional services at New York (N.Y.) Hospital. He was formerly assistant administrator of Rolling Hill Hospital, Elkins Park, Pa. Mr. Girard is a graduate of the Yale University program in hospital administration. He succeeds **Theodore E. McFarlan,** who has been appointed administrative director of the Central Manhattan Medical Group, Health Insurance Plan of New York.

● **R. L. Groff** has been appointed superintendent of Crawford (Nebr.) Memorial Hospital. He was formerly purchasing agent for Pennhurst State School, part of the Pennsylvania Department of Public Welfare.

● **James O. Hepner** (see Wolfe item)

● **Alvin Karp** (see Odell item).

● **Capt. Edward P. Kline (MC, USN)** has been appointed commander of Camp Pendleton, (Calif.) Naval Hospital, succeeding **Capt. Gerard B. Creagh (MC, USN)** who has retired. Capt. Kline was formerly executive officer of the hospital.

● **George W. Laycock** (see Rogers item).

● **Kenneth L. Lowery** has been appointed administrator of Shelby County Hospital, Alabaster, Ala. He was formerly an accounting technician with the Georgia Air National Guard. Mr. Lowery has also held the positions of medical supply technician and purchasing and contracting specialist with the Georgia Air National Guard. Mr. Lowery is a graduate of the Georgia State College of Business Administration program in hospital administration.

● **J. David Luckhaupt** (see Gillespie item).

● **William C. Mansberger** (see Nelson item).

● **Theodore E. McFarlan** (see Girard item).

● **Rear Adm. French R. Moore (MC, USN),** district medical officer of the Fifth Naval District, Norfolk, Va., has retired after more than 32 years of active naval service. During his naval career he served as executive officer, Navy Hospital, Long Beach, Calif.; executive officer, Navy Hospital, Philadelphia, and commanding officer, Navy Hospital, Newport, R.I.

● **John M. Nelson** has been appointed administrator of Lakeland Memorial Hospital, Woodruff, Wis., succeeding **William C. Mansberger.**

● **David L. Odell** has been appointed director of Olive View Sanatorium, San Fernando, Calif. He was formerly assistant director of Rancho Los Amigos Hospital, Downey, Calif. Mr. Odell is a graduate of the University of Minnesota program in hospital administration.

Alvin Karp has been appointed assistant director of Rancho Los Amigos Hospital, Downey. He was formerly personnel officer for the Los Angeles Department of Charities.

● **Joseph E. Peery Jr.** has been appointed administrator of Stevens Clinic Hospital, Welch, W. Va. He was formerly administrator of Marion (Va.) General Hospital. Mr. Peery is a graduate of the Medical College of Virginia program in hospital administration.

● **Walter S. Pugh, M.D.,** has been appointed manager of the Veterans Administration Hospital at West Haven, Conn. He was formerly manager of the VA Hospital in Wilkes-Barre, Pa. Dr. Pugh succeeds **Lewis G. Beardsley, M.D.,** who retired from VA service.

● **Herbert R. Rodde** (see Schwermin item).

● **James L. Rogers** has been appointed administrator of Cleveland Memorial Hospital, Shelby, N.C. He was formerly administrator of Spartanburg (S.C.) General Hos-

pital and was most recently treasurer of Converse College, Spartanburg. Mr. Rogers is a graduate of the University of Chicago program in hospital administration. He succeeds **George W. Laycock,** who has been appointed administrator of Brooker Memorial Hospital in Connecticut.

● **Frank J. Schwermin** has been appointed administrator of Highland Park (Ill.) Hospital. He was formerly assistant administrator of Englewood (N.J.) Hospital. Mr. Schwermin is a graduate of the Washington University program in hospital administration. He succeeds **Herbert R. Rodde,** who recently resigned.

● **Robert J. Scott, M.D.,** has been appointed manager of the Veterans Administration Hospital, Fort Wayne, Ind. He was formerly director of professional services at the VA Hospital in Richmond, Va. Dr. Scott succeeds **Michael H. Travers, M.D.,** who has been appointed director of VA domiciliary homes.

● **John Setsma Jr.,** has been appointed director of personnel at Good Samaritan Hospital, West Palm Beach, Fla. He was formerly administrator of William Crispe Hospital, Plainwell, Mich. Mr. Setsma is a graduate of the University of Minnesota program in hospital administration.

● **Josephine Sherman, R.N.,** has been appointed superintendent of Community Hospital, Hamburg, Iowa. She formerly held a supervisory position with the Corry (Pa.) Memorial Hospital.

● **Sister John Joseph** has been appointed administrator of Santa Rosa (Calif.) Memorial Hospital. She was formerly administrator of St. Luke Hospital, Pasadena, Calif.

● **Sister M. Anastasia, O.S.F.,** has been appointed administrator of St. Mary's Hospital, Nebraska City, Nebr., succeeding **Sister M. Pauline,** who has been transferred to St. Joseph of the Pines Hospital, Southern Pines, N.C.

● **Sister M. Patricia, O.S.F.,** has been appointed administrator of St. Joseph Hospital, Bryan, Tex. She was formerly a chemistry teacher in Toledo, Ohio. Sister Patricia holds a master's degree in hospital administration.

● **James P. Timmons** has been appointed assistant administrator of the Bexar County Hospital District, San Antonio, Tex. He was formerly auditor for the hospital district. Mr. Timmons, a certified public accountant is a graduate in business administration of the University of Oklahoma. The Bexar County Hospital system consists of Robert B. Green Memorial Hospital, Southton Convalescent Sanatorium, and Southton Tuberculosis Sanatorium.

● **Velmer P. Turnage** has been appointed administrator of Memorial Hospital of Decatur County, Bainbridge, Ga. He was formerly administrator of Scott County Hospital, Oneida, Tenn. Mr. Turnage is a graduate of the Georgia State College of Business Administration in hospital administration.

● **Maurice D. Wolfe** has been appointed an assistant director of the Jewish Hospital of St. Louis. He was formerly a staff management engineer with the hospital.

James O. Hepner has been appointed administrative assistant at the Jewish Hospital of St. Louis, effective upon completion this spring of his residency at the hospital; he is a student in the Washington University program in hospital administration.

● **Michael H. Travers, M.D.,** (see Scott item).

Special Notes

ANNIVERSARY: Sixty-one members of the staff of California Hospital, Los Angeles, were presented with gold membership cards in recognition of their tenure, ranging from 25 years to 61 years, with the hospital.

ANNIVERSARY: Hospital Care Association of Durham, N.C., (Blue Cross), celebrated its 25th anniversary.

ANNIVERSARY: **Lee S. Lanpher,** administrator, Lutheran Hospital, Cleveland, completed 25 years of service with the hospital. More than 500 employees and administrators of other Cleveland hospitals celebrated the event by holding a surprise party for Mr. Lanpher. Several gifts were presented to him, in addition to an album containing more than 150 letters.

ANNIVERSARY: Four employees who have each completed 25 years of service at the University Hospitals of Cleveland (Ohio) have been presented with gold watches. The four are: **Jane Lapacz,** personnel interviewer; **Emmett Markley,** patrolman; **Charles H. Pimlott,** assistant director; **Rosalie Weaver,** night nursing supervisor.

ANNIVERSARY: Lutheran Hospital of St. Louis (Mo.) has celebrated its 100th anniversary of service to the community.

ANNIVERSARY: Five Employees of Lankenau Hospital, Philadelphia, were given gold pins set with rubies, symbolizing their installation into the hospital's 20-year club. The five are: **Bertha Meyer, Harry Renshaw, Anna Ruckgaber, Sister Amelia Schaeffer, Thelma Thompson.**

ANNIVERSARY: St. Mary's Hospital, Waterbury, Conn., celebrated its 50th anniversary.

ANNIVERSARY: **William K. Turner** has completed 10 years of service as director of Newport(R.I.) Hospital.

HONORED: **Irving S. Cooper, M.D.,** director of the department of neurosurgery at St. Barnabas Hospital for Chronic Disease, Bronx, N.Y., was awarded a citation by the hospital's board of managers in recognition of "distinguished leadership and outstanding contributions to medical science and to the professional services of St. Barnabas Hospital in the field of neurosurgical research and the treatment and alleviation of extrapyramidal disorders." Dr. Cooper was credited with developing a new type of brain surgery, chemopallidectomy, in which a chemical takes the place of the scalpel.

DR. COOPER

Deaths

● **John C. Hubbard, M.D.,** died on March 18 after a long illness. He had been active in Oklahoma hospital and medical fields since 1926, when he founded the Hubbard Hospital at Oklahoma City. A recently published book, *Oklahoma Rebel,* was based on Dr. Hubbard's life. He is survived by his widow and three sons.

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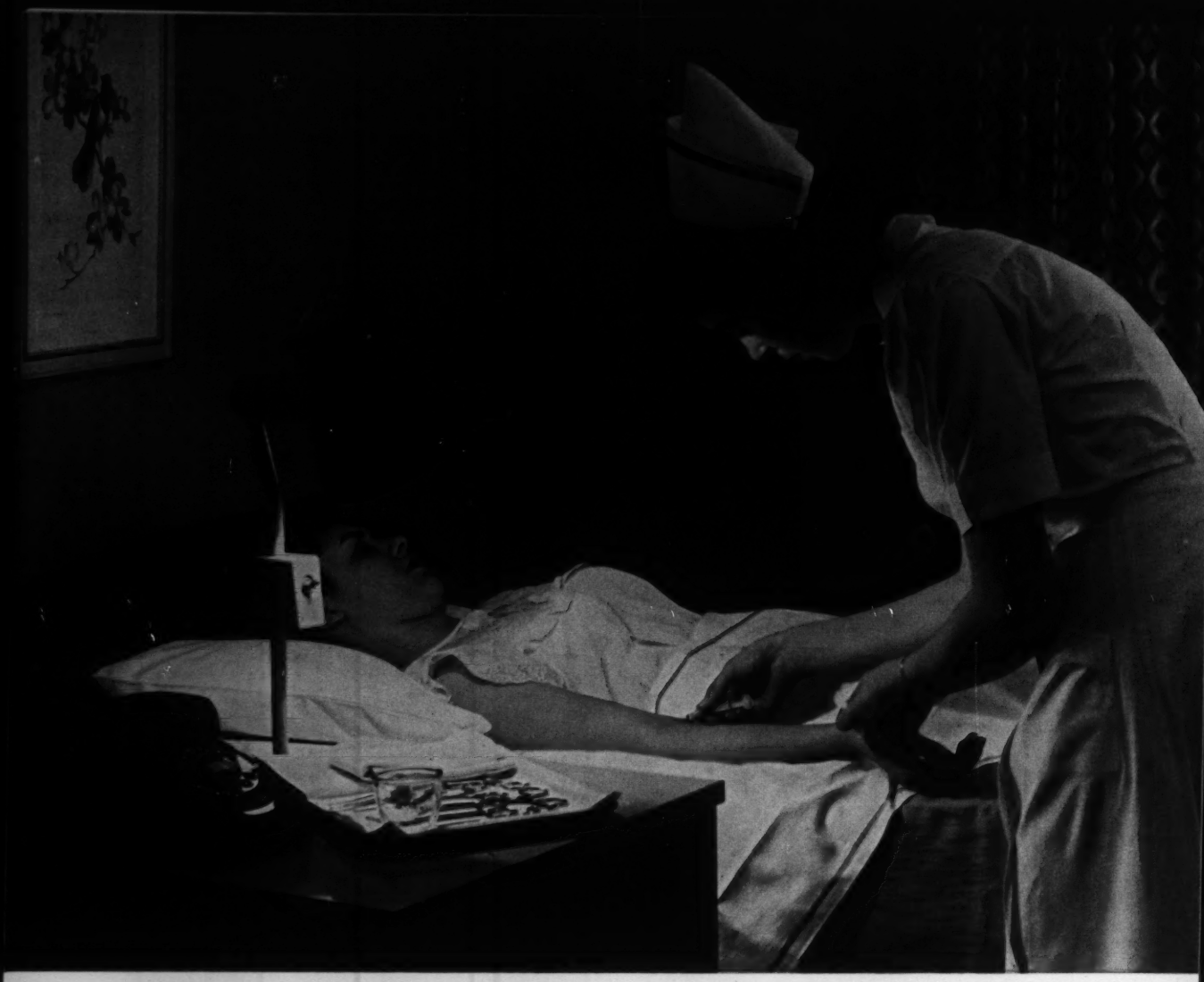

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AT RIGHT: *The Hill-Rom No. 307 Bedside Lamp reflects the light on the reading matter—not in the patient's eyes.*

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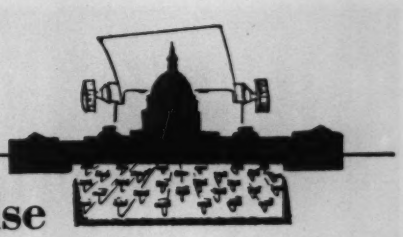

Committee Seeks Hill-Burton Raise

Under the leadership of Rep. John Fogarty (D-R.I.) a sum of $143.7 million has been recommended by the House Appropriations Committee for the Hill-Burton program for fiscal 1960.

This is a $42.5 million increase over the $101.2 million proposed in the Eisenhower administration budget. Last year Congress voted $186.2 million for Hill-Burton.

The House committee's increase for Hill-Burton was for Part C, the basic construction program. The administration had budgeted an allotment of $79 million for Part C in fiscal 1960. The House committee increased this figure to $121.5 million.

Budget proposals for the four special categories under Hill-Burton were the same under the administration and House committee recommendations:

Diagnostic and Treatment Centers	$6.5 million
Chronic Disease Hospitals	6.5 million
Rehabilitation Centers	4.0 million
Nursing Homes	4.0 million

The committee also voted $1.2 million for hospital research, the same as the administration sum.

In a report critical of many administration budget proposals, the House committee voted increases for numerous federal health programs including medical research, practical nurse training, and Public Health Service hospitals.

Sen. Lister Hill (D-Ala.), chairman of the Senate Health, Education, and Welfare and Labor Appropriations Subcommittee, said the House committee "did my work for me." In recent years, the Senate has voted even larger sums than the House for Hill-Burton and other health programs. Sen. Hill indicated that he expected the Senate to do so again.

The House committee's report, submitted by Rep. Fogarty, declared that the administration's budget proposal for Hill-Burton "was so completely out of line with the obvious needs and demands for this program, that it could not, under any circumstances, be accepted by the committee."

The report continued: "The budget was based on providing only sufficient additional hospital facilities

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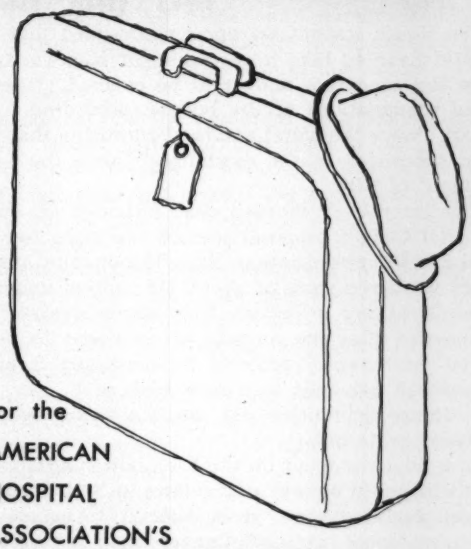

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to take care of the increase in population and the loss of hospital facilities through destruction, such as fire. There was no allowance made for replacing obsolete hospital facilities and there was no provision for making inroads into the enormous backlog of need that exists."

Nurse Training Programs

Professional Nurse—No funds were provided in the budget for the professional nurse training grants since this program expires June 30 unless extended by Congress.

Practical Nurse—The House committee, however, voted to restore to $4 million the amount for practical nurse training next year. The administration had reduced this amount to $2.9 million in line with its recommendation that the states take complete responsibility for the program by 1961.

Public Health Nurse—The House report noted that little testimony was given by PHS officials on the program of public health nursing. The committee said it hoped "this is not an indication they feel such a program is unimportant," and that it expects more information from PHS during next year's hearings.

Budget for Medical Research

The House Committee denounced the administration budget proposals most bitterly on the matter of medical research funds under the National Institutes of Health. A comparison of NIH budget proposals follows (figures given in millions of dollars):

	1959 Appropriations	Administration Proposal for 1960	Committee Proposal for 1960
General Research	$ 28.9	$ 28.9	$ 36.4
Cancer	75.2	75.2	83.3
Mental Health	52.4	52.3	60.4
Heart Diseases	45.6	45.6	52.7
Dental Health	7.2	7.2	7.2
Arthritis and Metabolic Disease	31.2	31.2	37.9
Allergy and Infectious Disease	24.0	24.0	30.2
Neurology and Blindness	29.4	29.4	33.6
TOTAL	$294.3	$294.2	$344.2

The House committee report maintained that NIH "would have to take a very distinct backward step were the executive budget to be enacted." The detailed explanations of the budget, according to the report, "were the worst and most confusing that have been submitted to the committee" since the establishment of NIH.

The committee charged that although in dollars the NIH budget proposal seemed the same for 1960 as the 1959 appropriation, this did not take into account increased costs of about $15 million under the administration's proposal. The administration recommended that the amount of overhead to be allowed on research projects be increased from the present 15 per cent to a new high of 25 per cent. The House committee did not allow the overhead increase in its bill.

In a final comment on the Eisenhower administration's balanced budget as it relates to NIH, the House report declared that "it is difficult to conceive of anything more anti-inflationary than a successful medical research program."

Other selected areas in House committee report:

CONSTRUCTION OF RESEARCH FACILITIES—The House committee voted $30 million for the construction of

medical research facilities, an increase of $10 million over the administration request. The same amount was appropriated in fiscal 1959.

PUBLIC HEALTH SERVICE HOSPITALS—Public Health Service hospitals were voted an increase by the committee of $934,900 above budget proposals. The committee declared that "this represents the first step in bringing the medical care given in these PHS hospitals to the level felt, by groups of outside professional personnel who reviewed their operations, to be the minimum for good medical service." The committee also spoke in favor of a medical research program in PHS hospitals.

INDIAN HEALTH—The House committee bill includes $45.5 million for Indian health, an increase of $2 million over the budget request, and $3.1 million above the 1959 appropriation. Under the committee's proposal, $4.5 million would be earmarked for construction of Indian health facilities; this is $1.5 million above the proposed budget figure, but $1.2 million below the 1959 appropriation.

AHA Heard by Committees

The American Hospital Association made appearances in April before two congressional committees. The hearings involved low interest hospital construction loans and federal employees health insurance.

HOSPITAL CONSTRUCTION LOANS—On April 21, AHA testified before the House Banking and Currency Committee on a billion-dollar community facilities loan program. The Association's views were presented by Dr. Robin C. Buerki, director, Henry Ford Hospital, Detroit, and chairman of the AHA Council on Government Relations. Main points made by Dr. Buerki were:

(a) Any federal hospital loan bill should be coordinated with the Hill-Burton grant program.
(b) Funds should be provided specifically for renovation and replacement purposes.
(c) The program should provide a 30-year minimum for all loans with direct application from federal government to borrower.
(d) Loan interest rates should not exceed 1.5 per cent.

Dr. Buerki told the committee that many hospitals cannot obtain loans through commercial channels. He said that hospitals have demonstrated they are good loan risks and asked that rigid loan requirements not be imposed upon any program developed by Congress.

FEDERAL EMPLOYEES HEALTH INSURANCE—Testifying before the Senate Post Office and Civil Service Committee, AHA gave its approval to a Senate bill supporting federal contributions for federal employees health insurance.

The Association said the bill formed a better base from which to develop satisfactory legislation than the current proposal of the administration's Civil Service Commission.

AHA was joined by Blue Cross, Blue Shield, and labor unions in opposing the Civil Service Commission's proposal. J. Douglas Colman, vice president of the Blue Cross Association spoke for Blue Cross. He said that Blue Cross Plans would support the Senate measure "with certain changes which we believe improve its consistency and clarity."

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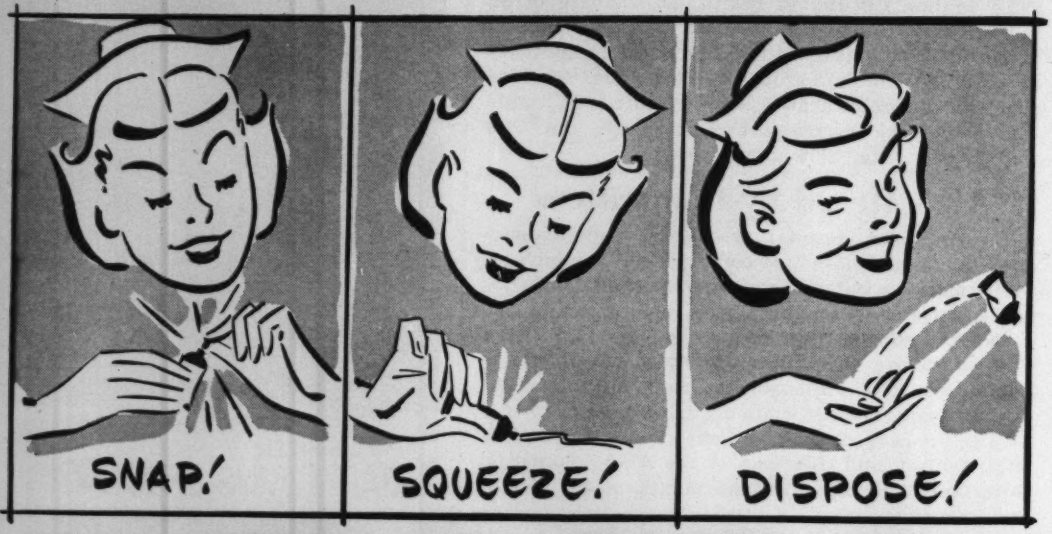

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BLUE CROSS PLAN REPRESENTATIVES TOLD—

Public Interest in Health System Grows

The public demand for "proof of the efficiency of our health system" was one of the recurrent themes of the Annual Conference of Blue Cross Plans held in Miami Beach last month. Another was the need for wider prepayment benefits. A third was the public willingness to pay for high quality medical care—once convinced it was getting its money's worth.

William S. McNary, executive vice president, Michigan Hospital Service (Blue Cross), said "the public wants proof [of this efficiency] and unless we provide such proof we are going to be in even worse trouble than we now are. This is our biggest problem. It will not disappear. We can't sweep it under the rug. We must face it . . .

"The alternative, of course, is slow strangulation of voluntary health insurance, followed inevitably and promptly by deterioration of our health care system."

A similar tack was taken by Francis R. Smith, insurance commissioner for Pennsylvania, the author of the well-known adjudication concerning Blue Cross rate requests in that state.

PUBLIC DEMANDS ANSWERS

Commissioner Smith said "the American public is demanding more and better answers to the economic and scientific questions regarding health than ever before and we in government and you in Blue Cross and Blue Shield must supply those answers." He said the public not only demanded the answers but demanded the right to ask the questions. "For my part, as a politician," he said, "I know enough not to tell the public that it has no business asking questions, that it should run along and leave its concerns to its betters. Yet surprisingly, this is the mood of many public comments from hospital people and doctors. Even some of your groups have at times adopted a similar attitude. . ."

The commissioner said that if the answers were not forthcoming from hospitals and prepayment plans, "I, as a politician, will be forced to get the answers for our public. My answers may not be the same as yours—they may not even be right. But nature abhors a vacuum . . . demonstrations of the truth will have to be made in a thousand ways to answer the public's questions."

George R. Metcalf, a member of the New York State senate, told the conference that the nonprofit prepayment plans were "quasi-public agencies and this 'quasi' is now being pushed more and more into the background and the plans are becoming more and more public."

BETTER CARE WANTED

Dr. Edwin L. Crosby, director of the American Hospital Association, told the conference that he was convinced that the American public wanted better health care and was willing and able to pay for it. "It is our job," he said, "to demonstrate to the public that we are delivering this health care as efficiently and as economically as possible."

On the subject of wider benefits, Carl M. Metzger, of Buffalo, N.Y., president of the Blue Cross Plan in western New York, said that evidence was available on every hand that the people were more interested in benefits than in cost. He said that the Blue Cross plans "which have the broadest benefits and which thereby reflect the highest subscription charges, are also the plans which have been most successful in enrolling the highest percentage of their area's population." The public demand for greater coverage

MR. MANNIX

MR. METZGER

was also stressed by Sen. Metcalf who pointed especially to what he called inadequacy of coverage of mental illness. He called for a "salvo from Blue Cross guns" to remove the obstacles to such coverage.

FREE SERVICE REIMBURSEMENTS

C. Rufus Rorem, Ph.D., executive secretary of the Philadelphia Hospital Council, said that the public hearings on Blue Cross were "basically an expression of the desire that Blue Cross make every effort to obtain maximum benefits for their subscribers." He said that most of the financial difficulties of the voluntary hospitals have arisen, "from disagreement over who is to pay for what a hospital is required to give away. Community demands for free service are not always accompanied by community willingness to reimburse its institutions for such care" and "taxing authorities have been notorious for making demands upon voluntary hospitals beyond the government's willingness to reimburse the institutions." He also called for Blue Cross participation in coordination and planning of the total hospital system of a community.

COMMUNITY PLANNING

Discussing one example of community planning, John R. Mannix,

New Members of AHA Blue Cross Commission

Four new commissioners to the Blue Cross Commission of the American Hospital Association were named during the Annual Conference of Blue Cross Plans at Miami Beach.

Two of the commissioners, Raymond K. Swanson, superintendent of Swedish Hospital in Minneapolis, and Tol Terrell, immediate past president of the AHA and administrator of Shannon West Texas Memorial Hospital, San Angelo, will serve three years.

Two commissioners who will serve two years are Sam J. Barham, executive director of Kansas Blue Cross, Topeka, Kansas, and F. P. Rawlings Jr., president of the Washington, D.C., Blue Cross Plan. ■

executive vice president of Blue Cross of Northeast Ohio, said that a careful study made in the Cleveland area had shown that an empty hospital bed cost $6500 per year to maintain, some 75 per cent of the $8200 annual operating cost of an occupied bed. He said careful planning in the Cleveland area has resulted in the trimming of proposals for new beds with a saving of 450 projected beds. This, he said, meant an initial construction saving of $7.6 million to the community and an annual saving of $4 million in operating funds.

Mr. Mannix pointed out that the study, done by an independent citizens committee had refuted the "misconception" that there is a great deal of abuse of hospital services by unnecessary admissions, overuse of special services, and length in stay.

At their business sessions, the Blue Cross Plans recommended that all Plans adopt, "as rapidly as possible, a policy providing group benefits at group rates for all retirees of established Blue Cross groups which have formal pension programs from which deduction can be made on a monthly basis." The Plans also urged development of programs for the aged to cover those not eligible for group benefits. The Plans supported a national nongroup enrollment program.

KIMBALL AWARD

George A. Newbury received the second annual Justin Ford Kimball award. Named for the father of the Blue Cross movement, this award is given for outstanding service to the voluntary prepayment movement. Mr. Newbury is the unpaid chairman of the board of the Blue Cross Plan in Western New York, and president of the Manufacturers and Traders Trust Company, Buffalo, N.Y. ■

TRI-STATE ASSEMBLY HEARS—

Hospitals Must Consider Public and Union Needs

The role of hospitals as community health centers and rising hospital costs received considerable attention from speakers at the 29th annual Tri-State Hospital Assembly, April 27-29, in Chicago.

The 8500 registrants from the four participating states who attended the assembly also heard about the increasing public criticism of hospital operation, growing union interest in hospital costs, and the need for medical service both in and out of hospitals.

Dr. Aims C. McGuinness, in the opening address of the meeting, said, "The hospital is the matrix of modern medical care. Its free and independent status must be held secure." Dr. McGuinness, special assistant for health and medical affairs to the secretary, Department of Health, Education, and Welfare, predicted that "the solutions to the health problems that lie ahead . . . will come out of the combined experience and cooperative enterprise of many groups and individuals." He said that there has been a change in thinking about hospitals and the services they provide, and that "there is a growing conviction that the general hospital should make its full resources available to serve the health needs of the entire community."

James Brindle, director of the Social Security Department of United Auto Workers, read to the assembly a paper prepared by UAW Vice President Leonard Woodcock. In it Mr. Woodcock supported hospital-centered group medical practice as the surest method to meet community health needs.

"Hospital people have long projected the image of the hospital not merely as a doctor's workshop but as a community health center —a place where physicians can work with other health professions, a place for medical education and research," he said.

RISING COSTS

George Bugbee, president of Health Information Foundation, New York, in discussing the problem of rising costs, said that "the public clamor over excessive use of hospitals and the questions raised about the efficiency of individual hospitals are matters of serious public concern. These criticisms could lead to hasty action that would control the flow of money into the health field. They could bring the imposition of cumbersome controls on individual hospital operation," he said.

Mr. Bugbee and other speakers pointed out that even though salaries and wages constitute about

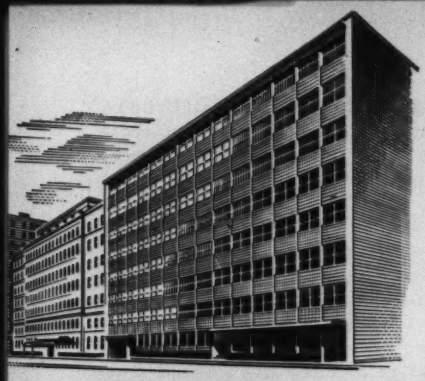
Program Held for Trustees

The Hospital Council of Philadelphia held its Second Annual Hospital Trustee Institute on March 31. Theme of this year's institute was "Trends in Hospital Finance."

Dr. Edwin L. Crosby, director of the American Hospital Association, spoke on the subject of "Trends in Hospital Operating and Capital Costs"; Jerome Preston, president of Massachusetts Memorial Hospitals, Boston, discussed "Patient Income in Hospital Finance," and George Bugbee, president of the Health Information Foundation, reviewed "Taxation and Philanthropy in Hospital Finance."

REVIEWING trustee relationships to hospitals are (l to r): C. Rufus Rorem, Ph.D., executive director of the Hospital Council of Philadelphia; Brandon Barringer, chairman of the council's Second Annual Hospital Trustee Institute; Dr. Edwin L. Crosby, director of the American Hospital Association. The institute was held March 31.

The afternoon session consisted of a panel discussion with the audience participating. ■



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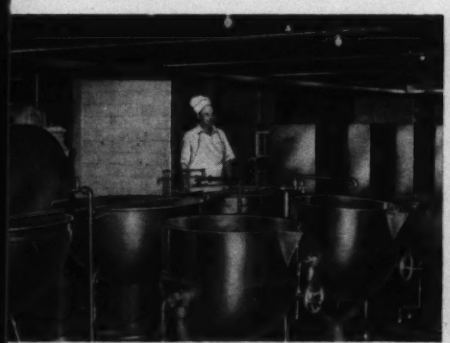

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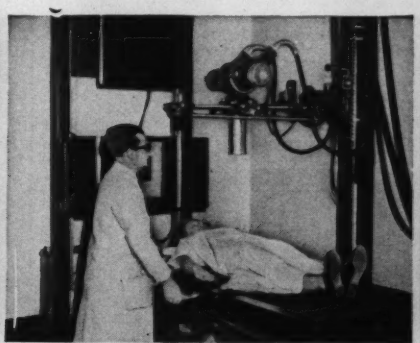

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70 per cent of hospital operating costs, hospital employees still are generally underpaid. This fact should be used in defending hospital costs to the public, Mr. Bugbee suggested.

RETAIN LOCAL CONTROL

Dr. Russell A. Nelson, president-elect of the American Hospital Association and director of Johns Hopkins Hospital, Baltimore, said hospitals must cooperate with government, but they must retain local control by maintaining an awareness of community needs. He warned that more controls, such as determination of rates by the states, are a live possibility. The alternative, Dr. Nelson pointed out, is for hospitals to impose their own controls and supervise their activities through state hospital groups.

EMPLOYEE TIME PLANNING

How hospitals are cutting expenses by improved planning of employee time was illustrated during a conference on methods improvement, which included demonstrations of problem-solving techniques. A team from the University of Illinois Hospital, Urbana, showed that to eliminate unnecessary and time-consuming procedures it is necessary to find out who instituted them and for what reason, and to determine if they cannot be eliminated altogether.

George L. Deschambeau, methods engineer at Michael Reese Hospital, Chicago, stressed the importance of determining that a hospital gets a fair day's work from each employee.

"If we don't know what a fair day's work is," Mr. Deschambeau said, "the unions will come in and show us."

OVER-USE OF HOSPITALS

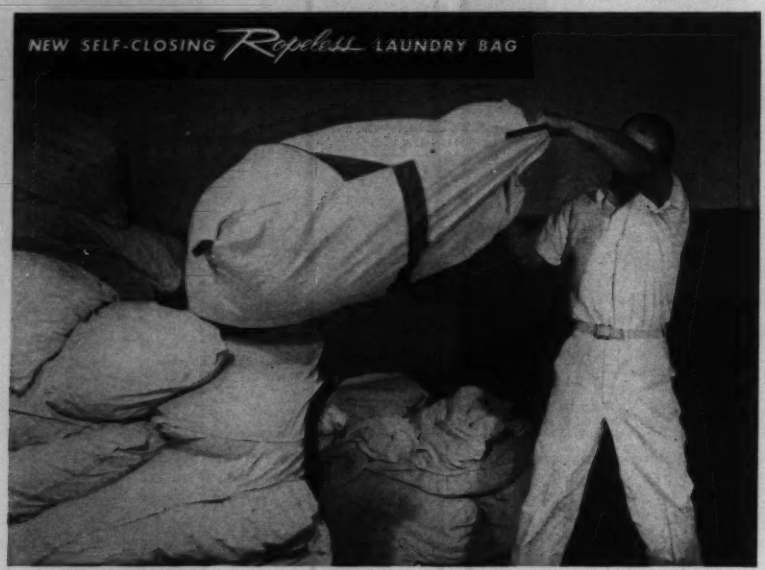
The role of the physicians and of the general public in preventing over-use was stressed by several speakers, though Dr. Robert Mustell said that one of the factors contributing to high costs is the "failure of the hospital to screen medical cases that could be treated at home."

Dr. Mustell, chairman of the Emergency Medical Service, Chicago Medical Society, said that the medical profession, hospitals and insurance companies all affect the costs of medical care. The medical profession fails in keeping costs down, he said, because some physicians fail to assume their share of home care. Insurance companies, Dr. Mustell believes, contribute to the problem through inadequate coverage of home medical care and too much coverage of inhospital medical care.

Dr. Mustell suggested a home care program that would originate in county medical societies. He said the county medical society "must first choose a member as director, then establish its medical panel, provide a 24-hour telephone service, and develop its clerical system."

John Fewkes, president of Chicago Teacher's Union Local No. 1, called for development of plans to provide for medical needs both in and out of hospitals. He said that legislators, unions, consumers—all groups must work together in planning medical care.

Mr. Fewkes pointed out that present plans generally have three common failures: (1) their cost is too high, (2) they do not provide adequately for the needs of population moving from one geographical area to another, and (3) they have not solved the racial discrimination problem. ■



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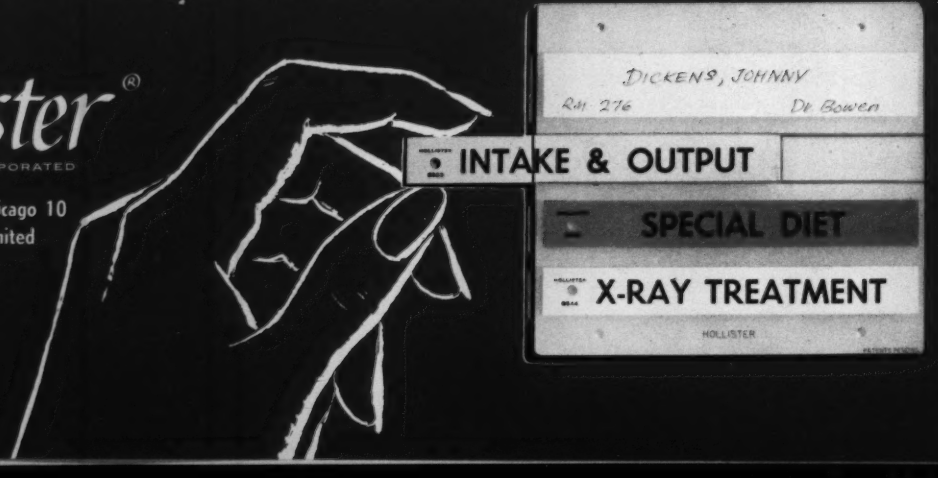
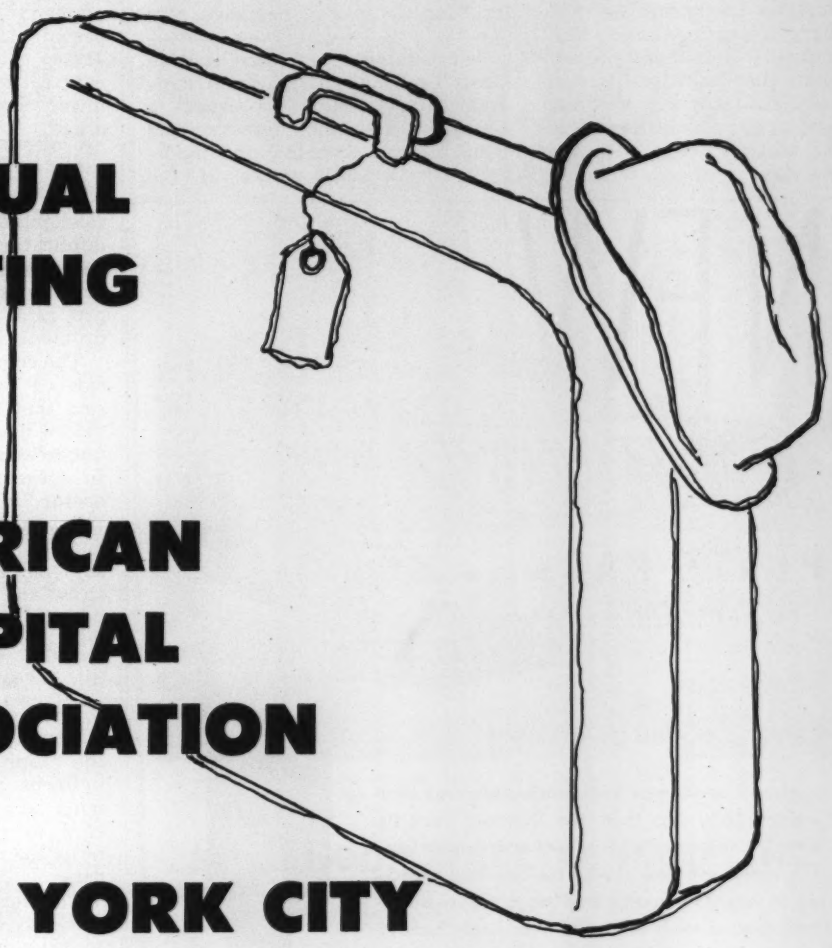


ATTEND THE 61st ANNUAL MEETING OF THE AMERICAN HOSPITAL ASSOCIATION IN NEW YORK CITY FROM AUGUST 24-27, 1959



For the first time since 1911 (the 13th Annual Meeting), the AHA will meet in New York City. A challenging program is rapidly taking shape, featuring distinguished speakers from the hospital field and from industry. The largest Hospital Merchandise Mart—technical and educational exhibit—in the history of the AHA will give you the opportunity to examine and discuss equipment you may need for your hospital.

Combine a vacation in glamorous New York City, with four days of profitable meetings in the air-conditioned Coliseum. Make it a real holiday with your family!

NEW JERSEY RATE STUDY—

Committee Reviews Blue Cross Rate Problems

A preliminary report on Blue Cross rates and related problems in New Jersey has been submitted to Charles R. Howell, the state's commissioner of banking and insurance.

The report was based on a study done by a committee appointed by Mr. Howell in the spring of 1958, after Blue Cross rate hearings. The preliminary report stressed that the problems examined prevail throughout the country. It said that Blue Cross rates will continue to rise and urged that nation-wide action be taken to cope with the rate increases.

The committee felt that if Blue Cross continues to give full coverage, the public must expect a continued rate increase resulting from present economic and medical conditions. However, if the public insists on lower rates, it must accept reduced service benefits through such contract features as indemnity payments, coinsurance and deductibility. In New Jersey, however, these features are contrary to present Blue Cross policy; the committee did not recommend their adoption. It suggested, however, that the New Jersey plan offer an additional contract for subscribers preferring lower rates and more limited coverage.

PRO RATA PAYMENTS

The committee suggested steps to stop hospital insurance coverage duplication. It suggested that Blue Cross and commercial insurance companies work out a system of pro rata payments to solve this problem.

The committee's report also considered over-use of hospitals. It said that the public and the individual doctor must help to reduce unnecessary hospital admissions. In stressing the importance of the doctor in lowering Blue Cross rates, the report said ". . . his [the doctor's] greatest weapon is to say 'no' to the patient who desires an unnecessary stay in a hospital just because Blue Cross will pay for it."

BETTER GOVERNMENT SUPPORT

The report stated that county governments failed to compensate the hospitals fully for the care of indigent patients and that funds must be appropriated for indigent care to relieve Blue Cross and hospitals in carrying this cost burden.

The committee suggested that a publicity campaign be undertaken to acquaint the public with the need for voluntary contributions to hospitals for the financing of improvements and new construction. These funds would come partly from Blue Cross. At present, Blue Cross provides hospitals with a 7 per cent capital expenditure allowance and a 2 per cent repair and maintenance fund. ■

N.Y. Blue Cross Asks for Greater Rate Increase

The Associated Hospital Service of New York (Blue Cross) has applied to the state insurance department for an average 34.2 per cent increase in subscription charges, to become effective September 1.

Charles Garside, AHS board chairman and president, said the

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AHS board of directors voted for this action to halt the depletion of Blue Cross reserves and to provide for higher payments to hospitals.

In July 1958, the New York Blue Cross Plan asked for a 40 per cent rate increase, but received only an average of 22.3 per cent from New York State Superintendent of Insurance Julius S. Wikler. The 22.3 per cent increase became effective September 1958. Mr. Garside at that time termed the increase insufficient. In asking for the additional 34.2 increase, he said that the previous increase had proved "totally inadequate."

BLUE CROSS LOSSES

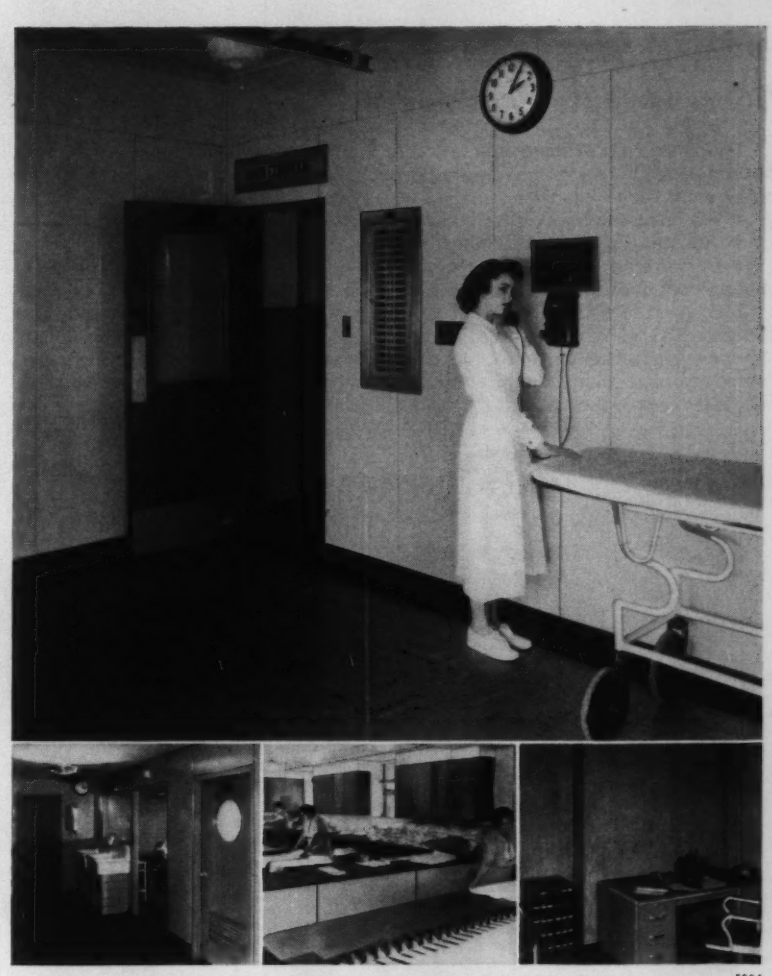
Mr. Garside pointed out that Blue Cross payments to hospitals exceeded income last year by more than $20 million and that Blue Cross paid out almost $5 million more than it received from subscribers during the first 1959 quarter.

The position of the New York Plan was further changed, Mr. Garside said, by a recent amendment to the state insurance law. The amendment reduced the required maximum contingent surplus reserve from 25 to 15 per cent; at the same time, it added a restriction which prevented the use of contingent funds except in the event of an epidemic or other catastrophe.

The AHS board of directors estimated that the organization's reserves would reach the 15 per cent mark by the end of September. In asking the state insurance department for prompt action, Mr. Garside pointed out that about 90 days are needed to give subscribers notice of rate changes.

NEW CONTRACT PLANNED

The proposed rate increases range from 17.3 to 48.4 per cent, depending on the type of contract. Mr. Garside stated that Blue Cross benefits would not change as a result of the proposed increase. However, AHS has been studying a new type of coverage for several months and has decided to prepare a new form of contract which would include protection of children from the time of birth, and also would add to present benefits provisions for nervous and mental disease care. Mr. Garside said, "The speed with which Blue Cross can introduce new benefits depends primarily upon action taken now to improve its present financial condition." ■



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IN WESTERN PENNSYLVANIA—

Increased Rates, Benefits Asked by Plan

The Hospital Service Association of Western Pennsylvania (Blue Cross) announced that it is seeking approval from the state commissioner of insurance for:

- An adjustment in subscriber rates on community agreements.
- Addition of new subscriber benefits.
- Permission to offer a new, lower-cost deductible agreement.

Increased rates for the Plan's 21-90 group agreement would average 33 per cent; the increase for the standard agreement would average 42 per cent—approximately 12.5 per cent of which would represent new benefits.

Approximately 1.4 million of the nearly 2 million Blue Cross subscribers in western Pennsylvania are enrolled under the community agreements for which increases are being sought, William H. Ford, president of the Plan, stated.

Subscribers covered by "master" agreements negotiated annually with management and labor will not be affected since "master" rates are based on current hospital costs, the Plan stated.

ADDED BENEFITS

The benefits to be added to the Blue Cross standard agreement include:

1. Coverage for outpatient diagnostic services.
2. Additional days of coverage for subscribers 65 years of age and older.
3. Visiting nurse care for subscribers 65 and older.

Pennsylvania's insurance department has already approved Blue Cross coverage for certain diagnostic services (x-ray, electrocardiograph or electro-encephalograph examination, basal metabolism) in the outpatient departments of hospitals.

Under the Plan's new filing, Blue Cross coverage for outpatient diagnostic services would be included in the standard agreement in combination with Blue Shield coverage for these diagnostic services when they are performed outside of hospitals. The proposed subscriber rates for the standard agreement include this Blue Shield coverage.

In addition to the diagnostic benefits, the Plan stated, revision of the standard agreement would make it possible for subscribers 65 years of age and older, who are now entitled to 21 days of coverage per contract year, to receive up to 66 full benefit days per year.

VISITING NURSE SERVICE

Over-65 subscribers would also be entitled to have visiting nurse service in place of unused hospital benefit days, immediately following care on an inpatient basis. Each visiting nurse home call is to be counted as a half day of hospitalization, with such visits limited to a maximum of 20 per hospitalization.

Under the Plan's proposed deductible standard agreement, to be available only on a semiprivate room basis, the subscriber will be required to pay to the Plan a deductible amount of $25 for a one-day hospital stay and $50 for hospital stays of two or more days. There would be an upper limit of liability of $50 within any 90-day

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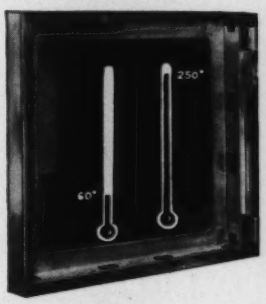

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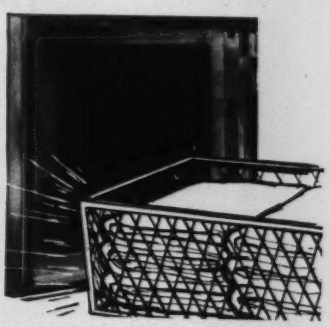

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INCO NICKEL ALLOYS

period for all persons covered. Other features of the plan would be the same as those under the standard agreement.

In announcing its increase requests, the Plan stated that "in 1958, Blue Cross had to withdraw $1,514,231 from its state-required reserves to pay for benefits and services to subscribers during the year. The first two months of 1959 have shown a loss of $718,721. Association reserves on Feb. 28, 1959, totaled $4,841,322, which is slightly less than the amount required to cover one month of average operation. Unless rates are adjusted, estimated losses in 1959 on the 21-90 and standard agreements will reach more than $4.5 million, with more than $3 million of this loss occurring by Aug. 1, the proposed effective date of the rate increase." ■

State Association Presidents

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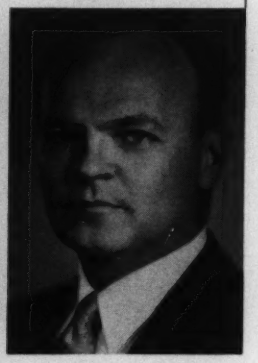
R. ASHTON SMITH
Director
Lawrence General Hospital
Lawrence

OKLAHOMA

RAYMOND CREWS
Administrator
University of Oklahoma
Hospitals
Oklahoma City

TEXAS



F. S. WALTERS JR.
Superintendent
Northwest Texas Hospital
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Carolinas-Virginias Group Hears Personnel Discussion

Every worker in an organization should know what his duties and responsibilities are so that the management-employee relationship will be a successful one.

This statement was made by J. Mitchell Graybard, director of personnel for a New York City investment banking firm, during the Carolinas-Virginias Hospital Conference, held April 16-17 in Roanoke, Va.

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ideas of what we know about working people," Mr. Graybard said. Worker loyalty, he continued, cannot be won with "gimmicks" such as house organs, bowling teams, and Christmas parties.

Dr. Edwin L. Crosby, director of the American Hospital Association, said that hospital charges will continue to rise, in part caused by the fact that Americans want "better hospital care not cheaper public service. They want better good refrigerators, not cheaper bad ice boxes."

Dr. Russell A. Nelson, AHA president-elect and director of Johns Hopkins Hospital, Baltimore, said that hospitals and personnel in the health field must make every effort to keep up with the public's needs for hospital care.

"The public, through education and hospital insurance, has demanded increased hospital services and this has led to uniformly higher hospital occupancies," he said. ■

Hudenburg Receives Award for Work on Hospital Safety

Roy Hudenburg has been named the recipient of the distinguished service award of the National Fire Protection Association.

MR. HUDENBURG

Mr. Hudenburg, associated with the Community Health Association, Detroit, is to receive the award, NFPA stated, "because of his important contributions to the NFPA in achieving for hospitals a workable set of requirements for the safe use of flammable anesthetics, and his efforts in advancing safety to life from fire."

He has served on NFPA's Hospital Operating Rooms Committee for 10 years as the American Hospital Association's representative and is presently chairman of the committee. Mr. Hudenburg is also a member of NFPA's Committee on Life Safety and the Subcommittee on Nursing Homes and Hospitals. ■

Dr. Crosby Announces HOSPITALS Staff Change

Dr. Edwin L. Crosby, director of the American Hospital Association, has announced the appointment of Rex N. Olsen as managing editor of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. Mr. Olsen has been assistant managing editor of HOSPITALS since 1956. He succeeds Aaron Cohodes, who resigned last month.

A graduate of the University of Missouri School of Journalism, Mr. Olsen has been active in the periodical and book publishing fields for the past nine years. ■

Felix Lamela Named Director of Puerto Rican Blue Shield

Felix Lamela has been appointed director of Blue Shield of Puerto Rico. He is a fellow of the American College of Hospital Administrators and has held positions with the Rockefeller Foundation, University of Puerto Rico, Columbia University, Pan American Union, Institute of Inter-American Affairs, and the World Health Organization.

MR. LAMELA

Mr. Lamela was one of the

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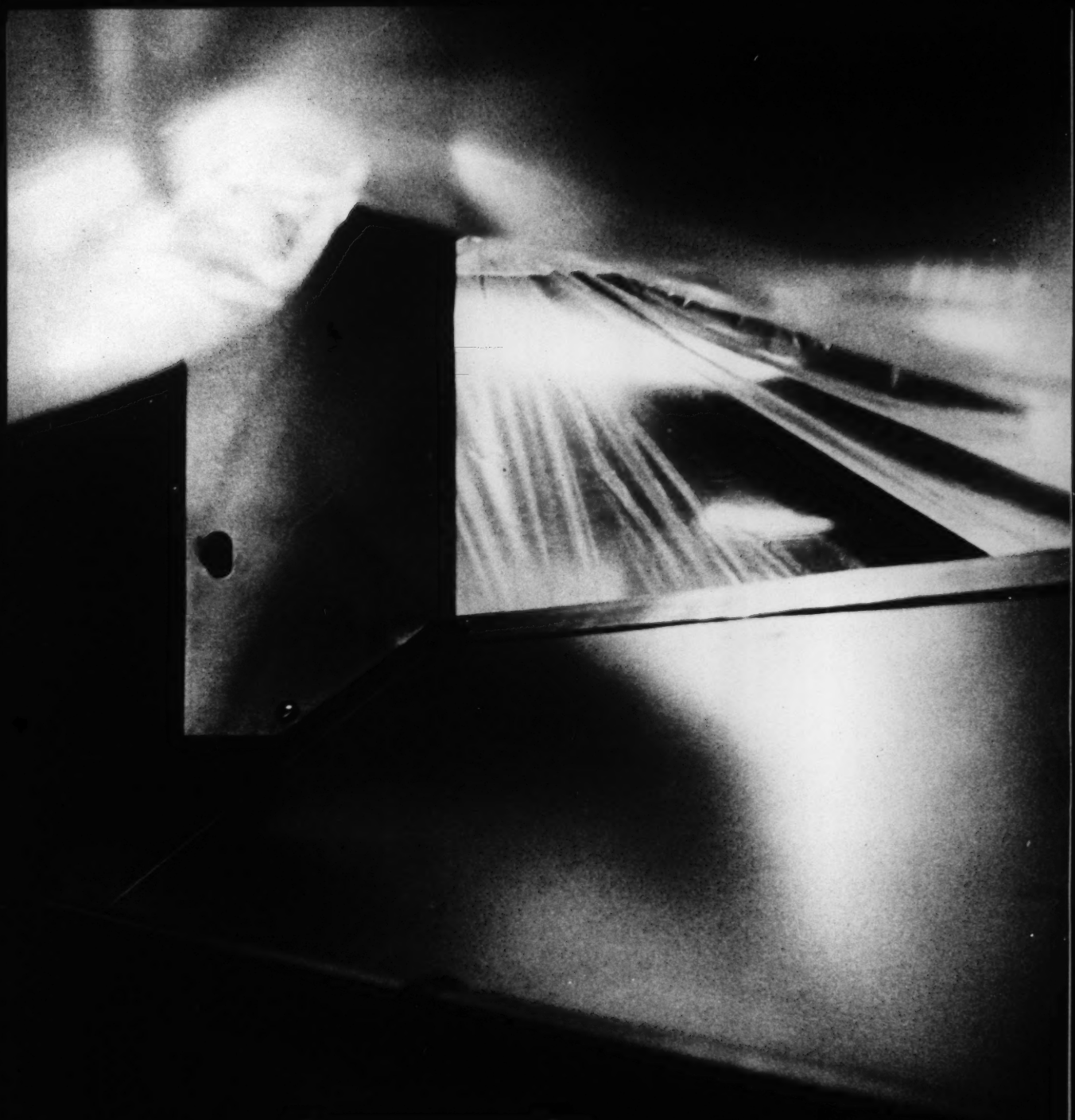

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founders of Blue Cross in Puerto Rico and the first president of its board of regents. ■

Blue Cross Plans Issue 1958 Financial Report

The 1958 financial report of the Blue Cross plans, covering the activities of 83 plans, shows that total expenditures during the year for hospital care of members reached an all-time high.

The plans reported that more than $1 billion was spent on hospitalization costs, representing approximately 97 per cent of the total subscriber income of $1,400,-917,900. Operating expenses amounted to 5.91 per cent of that income, a new low. However, the total of hospital and operating expenses exceeded total subscriber income, leaving the plans with a deficit of 2.80 per cent that had to be taken out of reserves during 1958. This amounted to nearly $40 million. During the previous year, only about $8 million were taken from reserves.

ASSETS DECREASED

The assets of the Blue Cross plans decreased during 1958 by $1,021,454 (.17 per cent) to $610,-318,836. The 83 members had total hospital expenses of $1,357,392,014 during 1958, compared to total of $1,210,581,698 in 1957. The operating expenses amounted to $82,-762,574 in 1958, and to $76,894,037 in 1957. The Blue Cross had 85 member plans in 1957—two more than in 1958.

SIZE OF PLANS

On December 31, last year, 13 plans had more than one million members, 17 had between 500,000 and one million members, 24 between 200,000 and 500,000, and 11 plans had between 100,000 and 200,000 members. Five plans showed a membership of 50,000 to 100,000 and nine of less than 50,000. The New York City plan led in size with 7,109,810.

Of the plans reporting, 79 operated in the United States and Puerto Rico, and four in Canada. ■

Washington Hospital Group Moves to New Headquarters

The new address of the Washington State Hospital Association is 601 Broadway, Seattle 4, reported John Bigelow, executive secretary of the association. The association's former address was 370 Skinner Building, Seattle 1. ■

National Foundation Names Glasser to New Executive Job

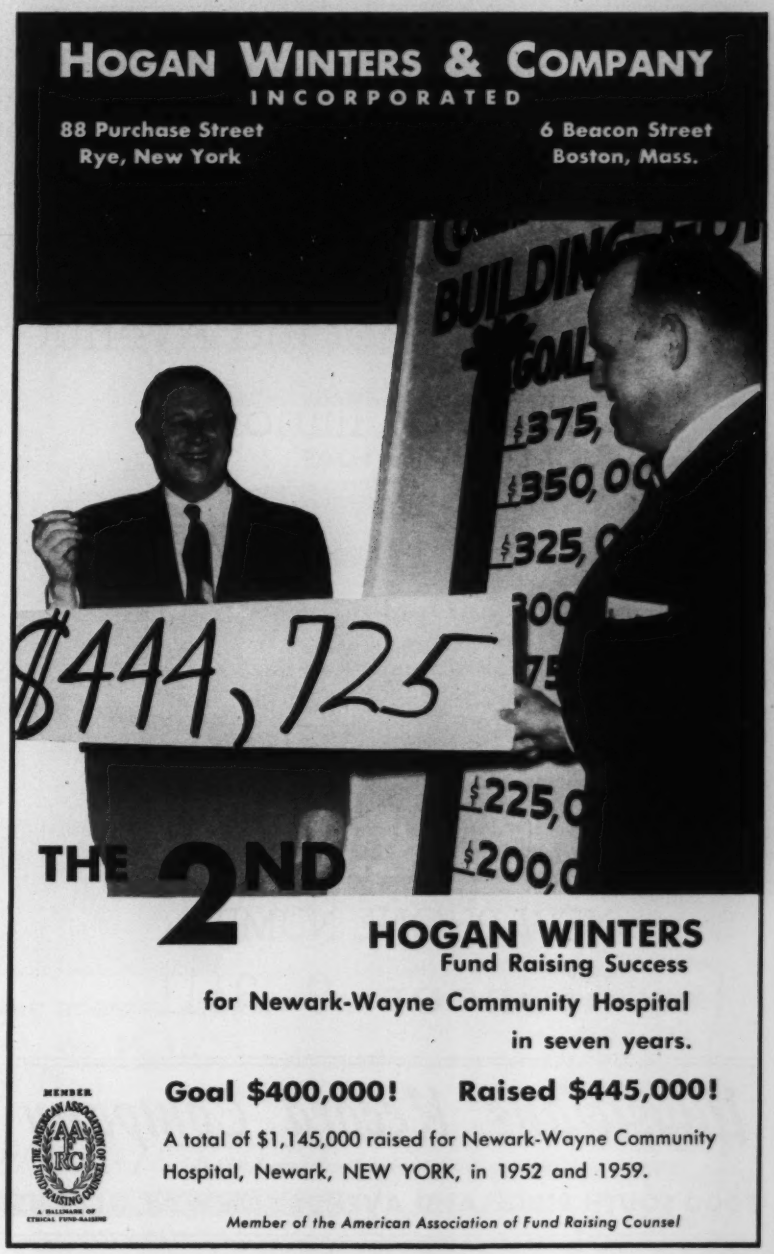
Melvin A. Glasser has been named executive vice president of the National Foundation, President Basil O'Connor announced. Mr. Glasser succeeds Raymond H. Burrows, who died in October 1958.

Mr. Glasser joined the executive staff of the organization six years ago (it was the National Foundation for Infantile Paralysis then) and was appointed deputy executive vice president last year. He directed the evaluation studies that led to expansion of the March of Dimes-supported program into arthritis, birth defects, virus disease and disorders of the central nervous system, as well as polio.

He was, in 1954, administrative director of the nationwide polio vaccine field trial.

Mr. O'Connor also announced three other appointments:

- Joseph F. Nee was named vice president of operations. For the past 6 of his 13 years with the foundation, Mr. Nee has been national director of fund-raising.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• Hubert E. White was named treasurer, in addition to his duties as comptroller of the foundation.

• E. Burr Gibson was named director of fund-raising. He has been on the foundation's staff for 11 years, most recently as assistant executive vice president. ■

Hunt Relinquishes Position as Head of Blue Cross Plan

Clement W. Hunt has retired as executive director of Capital Hospital Service (Blue Cross), Harrisburg, Pa. He had been executive director of the Plan since it began in 1938.

Mr. Hunt will continue his affiliation with Blue Cross on a consulting basis.

Prior to joining the Blue Cross staff, Mr. Hunt had been a teacher, a superintendent of schools, and deputy commissioner of the Department of Public Welfare.

Richard D. Rife has been named to succeed Mr. Hunt as executive vice president. Mr. Rife has been employed by the Plan for 12 years, the last 5 of which he has served as administrative assistant and assistant executive director in administration. ■

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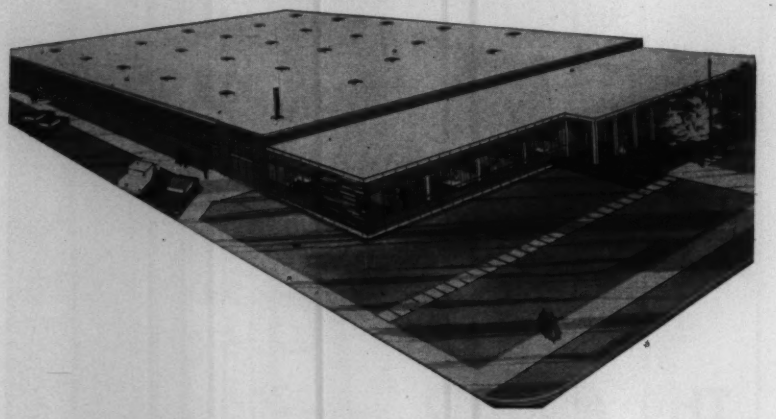

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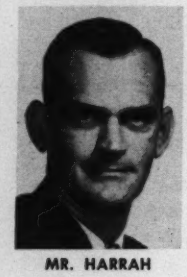
Galloway Accepts New Post With Georgia Blue Cross Plan

John M. Galloway has been appointed assistant executive director of Georgia Hospital Service Association (Blue Cross) and Physicians Service (Blue Shield), Columbus, Ga. He was formerly director of hospital and physician services for the Plans.

Mr. Galloway is a graduate of the Columbia University program in hospital administration and was at one time director of hospital and physician relations for the Virginia Hospital Service Association (Blue Cross) and the Virginia Medical Service Association, (Blue Shield) Richmond. ■

Pennsylvania Hospital Group Undertakes Personnel Study

Ivan O. Harrah has been appointed personnel associate on the staff of the Hospital Council of Western Pennsylvania. The appointment was made possible by a grant from the Sarah Mellon Scaife Foundation, for support of a hospital council project to adapt scientific industrial management methods for use in hospitals.



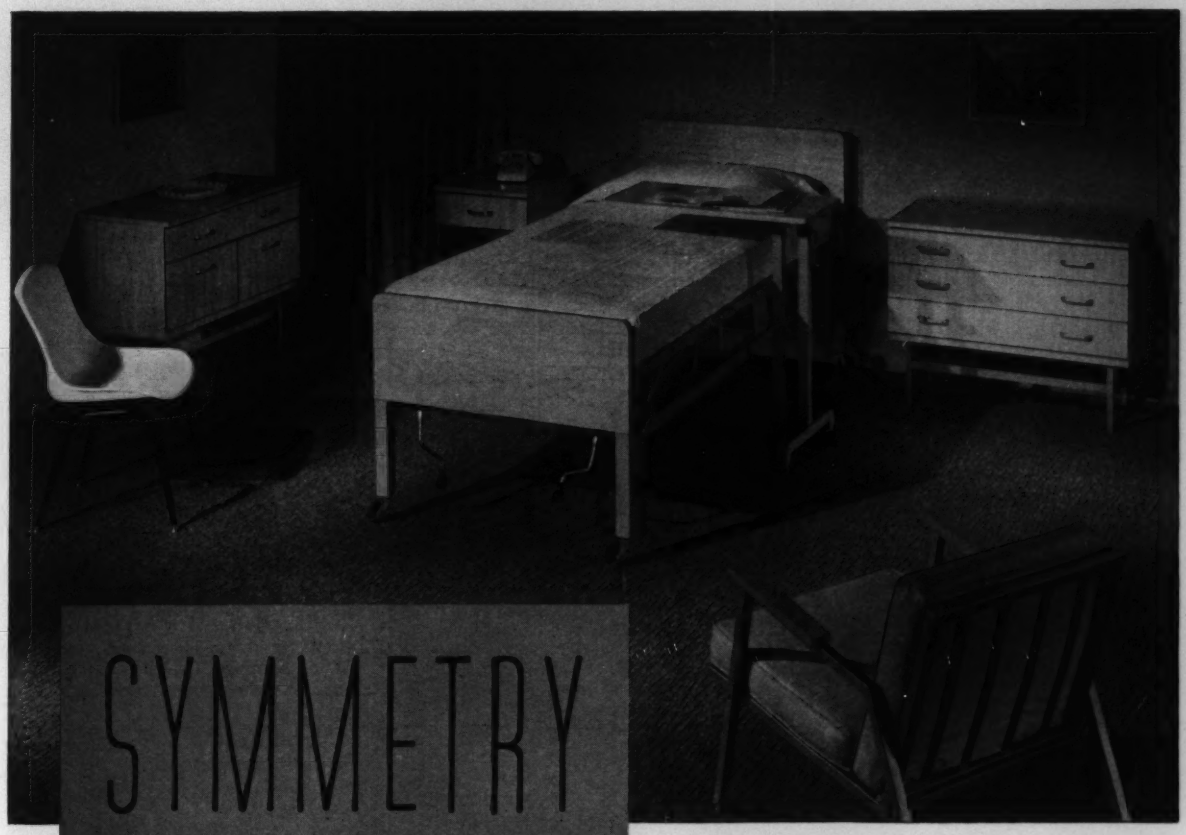
MR. HARRAH

Mr. Harrah was formerly associated with the Miners Memorial Hospital Association, which operates 10 general hospitals in the Virginia-West Virginia-Kentucky area.

The council's project, stated Robert M. Sigmond, executive director of the council, will be the design and installation of job and salary evaluation plans in the group's 64 member hospitals, following a pilot study. Ultimately the project's emphasis will shift to methods improvement, Mr. Sigmond stated. ■

Fund for Mental Health

A fund to help hospitals provide treatment for mental patients has been established by the Laramie County (Cheyenne, Wyo.) Mental Health Association. The association stated that the fund will be financed by private contributions made as memorials and that the money would be used by both of Cheyenne's nonfederal hospitals, De Paul Hospital and Memorial Hospital of Laramie County. ■



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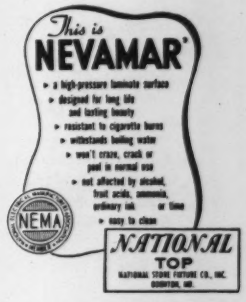
SEE OUR EXHIBIT AT MIDDLE ATLANTIC HOSPITAL ASSEMBLY
Convention Hall, Atlantic City, N.J., May 20, 21, 22
BOOTHS NO. 102-104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Mickelsen Named to Post With Blue Cross Commission

Robert L. Mickelsen has been named manager of the operations division of the Blue Cross Commission. He succeeds Walter F. Hachmeister, who has been appointed operations manager for Blue Shield Medical Care Plans, Inc., national association of Blue Shield Plans.

Prior to joining the Blue Cross Commission staff Mr. Mickelsen was office manager of Booz, Allen and Hamilton, Chicago management consultant organization, where he was responsible for personnel administration and policies, budget and cost analysis, purchasing, and formulation of office systems and procedures. ■

Dr. J. A. Dailey Appointed Rhode Island Health Director

Dr. Jeremiah A. Dailey has been named director of the Rhode Island Department of Health. Dr. Dailey retired from the Army on Jan. 31; before his retirement he was commanding officer of the 68th Medical Group, Fort George G. Meade, Md. ■

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California Names Dr. Blain As Mental Hygiene Director

Dr. Daniel Blain has been appointed director of mental hygiene for the state of California. Dr. Blain, 60, succeeds Dr. Marshall E. Porter who returned to his previous position as deputy director of mental hygiene.

DR. BLAIN

Until 1958, Dr. Blain was medical director of the American Psychiatric Association and since that time has been serving on a part-time basis as director of mental health work for the Western Interstate Commission on Higher Education. ■

AMA Names New Manager For Its Washington Office

The American Medical Association has announced the appointment of Dr. Roy T. Lester of Dallas as manager of the association's Washington office. For the past five years, Dr. Lester has been medical director of Texas Blue Cross-Blue Shield. The Dallas physician will take over the manager's post from Edwin Patterson, who will return as counsel to the Veterans Affairs Committee of the House of Representatives.

Dr. Lester has served on the Committee on Voluntary Health Insurance of the Texas State Medical Association and the Medical Economics Committee of the Dallas County Medical Society. ■

Colonel Haynes Appointed New NLN General Director

Colonel Inez Haynes, ANC, has been appointed general director of the National League for Nursing, effective September 1. Anna Fillmore will continue to hold the general directorship until June 1, when she will take over as executive director of the Visiting Nurse Service of New York.

COL. HAYNES

Col. Haynes has served as chief of the Army Nurse Corps for four years. Prior to that, she held various Army Nurse Corps assign-

This single White Latex Quixam Examination Glove fits either hand. Available in small, medium, and large sizes.

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ments in many parts of the world. Col. Haynes is currently chairman of the Council of Federal Nursing Services.

In her new post, she will head a 200-member staff. ■

Pharmacists Name Trygstad President; Heller Resigns

Vernon O. Trygstad of Washington, D.C., vice president-elect of the American Society of Hospital Pharmacists, has been appointed president-elect of the Society, succeeding William J. Heller, Ph.D., of Little Rock, Ark. Mr. Heller, who is director of the American Hospital Formulary Service, resigned to devote all of his available time to the development of the formulary service.

Mr. Trygstad will be installed as president at the Society's annual meeting in Cincinnati, Aug. 16-21. The position of vice president-elect will remain vacant until action is taken by the Society's executive committee. ■

VA Program for Blinded Veterans Gets New Chief

A war-blinded veteran, Russell C. Williams, has been appointed chief of the Veterans Administration rehabilitation program for blind veterans. The VA said Mr. Williams' appointment will bring him to the agency's central office in Washington from Hines, Ill. He has been chief of rehabilitation activities for the blind at the VA Hospital in Hines. The center, through the only program of its kind, has helped nearly 500 veterans adjust to their blindness and learn to use special tools and appliances.

Mr. Williams received the 1956 National Rehabilitation Award given by the American Veterans of World War II and the 1953 Achievement Award from the Blinded Veterans Association. ■

Public Health Service Offers Nurses Research Fellowships

Nurses interested in receiving additional training in the health sciences or in research methods in nursing may now apply for fellowships being offered by the Public Health Service. The only requirement is a bachelor's degree.

Based on need rather than a set stipend, these fellowships may be used for graduate research training leading to a master's degree, doctorate in education or a Ph.D. degree, on-the-job training in a research center, or a combination thereof.

Applications, which may be submitted at any time, should be didected to PHS, Department of Health, Education, and Welfare, Washington 25, D.C. ■

Health Problems of Aging Surveyed by Foundation

"Aging persons inevitably face special health problems, and most older people have health problems that bother them to some extent," the Health Information Foundation reports in its April bulletin, *Progress in Health Services.*

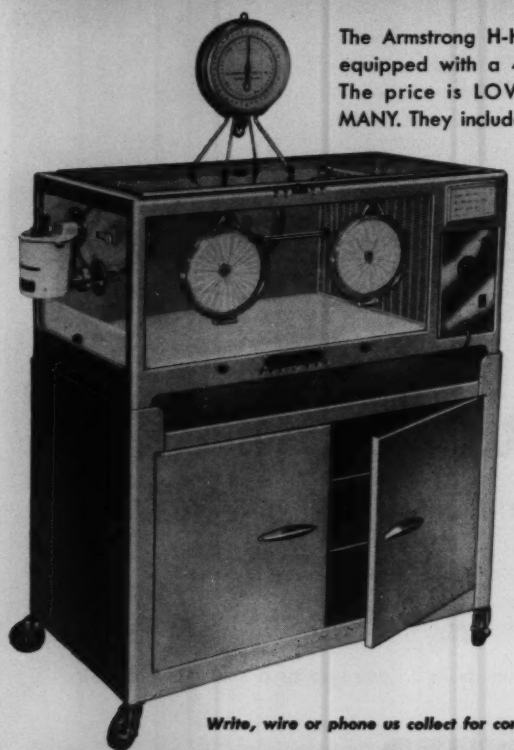
The study was made in cooperation with the National Opinion Research Center of the University of Chicago, in which a random cross-section of the U.S. population 65 years of age and older were interviewed at length about such items as their health, living arrangements, and income.

Major findings of the survey include:

- Approximately 85 per cent of the persons in the over-65 age group interviewed had had some health complaint or other illness

Armstrong H-H

Hand-hole type Baby Incubator



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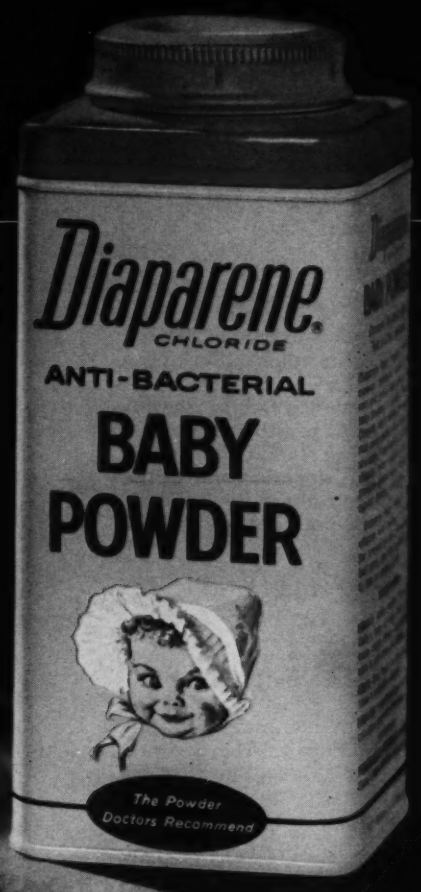

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*Antibiotic Resistant Strains

**Tests were done in quadruplicate with 8mm. diameter cup

This controlled laboratory experimentation once again confirms the efficacy of DIAPARENE CHLORIDE'S anti-bacterial activity.

This evidence provides scientific substantiation enabling physicians to prescribe DIAPARENE ANTI-BACTERIAL BABY POWDER with the utmost confidence that it provides effective prophylaxis in ammonia dermatitis in infants and incontinent adults.

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which bothered them within the four weeks prior to the survey.

- Only one out of every three persons interviewed who had a health complaint told a physician about it. The economic factor was a minor element in their reluctance to see a physician.
- Persons 65 and over averaged 7.6 visits to doctors a year per capita—approximately two visits a year more than the average for all age groups in this country.
- Among the older persons who had visited a doctor within the four weeks before the interview, four out of every five were able to pay for the service, either from their own income or savings, or with the help of a relative. ■

Health Technicians To Meet in Paris

The sixth International Congress of Health Technicians will convene in Paris, June 9-12. The main topics of discussion will be the role of the team of health technicians; and the living conditions of patients, of the wounded and in the postoperative cures in the hospitals of tomorrow, both public and private. ■

New Jersey Adds Ninth Outpatient Alcoholic Clinic

The state of New Jersey will have its ninth outpatient clinic for alcoholics after the opening of a clinic at Mountainside Hospital in Montclair. The hospital received a $10,000 grant for the operation of the alcoholic unit from the State Department of Health.

Dr. Paul Faber will head staff physicians who will take care of the alcoholic patients on a part-time basis. The clinic will also use a full-time social worker. In addition to treatment, the Mountainside unit plans to explore the patients' emotional and social problems that cause chronic drinking. ■

Hospital association meetings

(Continued from page 6)

14-16 Montana Hospital Association, Great Falls (Rainbow Hotel)
14-18 American Dental Association, New York (Coliseum)
21-24 **Operating Room Administration,** Denver (Cosmopolitan Hotel)
22-25 ***American Roentgen Ray Society,*** Cincinnati (Netherland Hilton Hotel)
23 Utah State Hospital Association, Salt Lake City
27-Oct. 2 ***American College of Surgeons, Clinical Congress,*** Atlantic City (Convention Hall)
28-Oct. 2 **Housekeeping-Laundry Joint Institute,** Chicago (AHA Headquarters)
28-Oct. 2 **Medical Social Workers in Hospitals,** Atlantic (Henry Grady Hotel)

OCTOBER

1 Hospital Association of Rhode Island, Providence (Sheraton-Biltmore Hotel)
5-8 ***American Academy of Pediatrics,*** Chicago (Palmer House)
5-8 **Nursing Service Supervision,** Boston (Somerset)
5-9 ***American Society of Anesthesiologists,*** Bal Harbour, Fla. (Americana Hotel)
6-8 ***American Nursing Home Association,*** Chicago (Morrison Hotel)
7-9 **Hospital Librarianship,** Chicago (AHA Headquarters)
8-9 Arizona Hospital Association, Flagstaff (Monte Vista Hotel)
8-9 Colorado Hospital Association, Colorado Springs (Antlers Hotel)
8-9 Mississippi Hospital Association, Biloxi (Hotel Buena Vista)
12-15 **Supervision,** Atlanta (Henry Grady Hotel)
12-15 ***American Association of Medical Record Librarians,*** Minneapolis (Radisson Hotel)
14-15 Indiana Hospital Association, Indianapolis (Student Union Building)
14-16 Saskatchewan Hospital Association, Saskatoon (Bessborough Hotel)
15-16 Nebraska Hospital Association, Lincoln (Cornhusker Hotel)
18-23 ***American Occupational Therapy Association,*** Chicago (Morrison Hotel)
19-20 Idaho Hospital Association, Boise (Elks Lodge)
19-20 Oregon Association of Hospitals, Coos Bay
19-22 **Staffing Departments of Nursing,** Minneapolis (Radisson Hotel)
19-23 ***American Public Health Association,*** Atlantic City (Convention Hall)
19-23 California Hospital Association, Yosemite (Ahwahnee Hotel)
20-21 North Dakota Hospital Association, Minot
20-21 South Dakota Hospital Association, Yankton
20-23 British Columbia Hospital Association, Vancouver (Vancouver Hotel)
21-22 Washington State Hospital Association, Yakima (Chinook Hotel)
26-28 Maryland-District of Columbia-Delaware Hospital Association, Washington (Shoreham Hotel)
26-28 Ontario Hospital Association, Toronto (Royal York Hotel)
27-29 Associated Hospitals of Alberta, Edmonton (Jubilee Auditorium)
28-30 Missouri Hospital Association, St. Louis (Sheraton-Jefferson Hotel)
29-31 West Virginia Hospital Association, White Sulphur Springs (Greenbrier Hotel)

Admitting the patient: a matter of good form

(Continued from page 45)

3. *The provision for interest has several purposes.* It creates an incentive for payment by a delinquent debtor. When interest is added to his bill, his interest in payment is revived. This is also important in collecting claims against probate estates. Executors and administrators as a matter of practice delay the payment of all bills that do not bear interest. By reference to the "legal rate" the hospital incorporates a rate of interest that is usually higher than the going commercial rate.

4. *In actual practice, the hospital will ordinarily waive the provision for attorneys' fees and interest for an immediate payment of a delinquent account.* In other words, when the patient wants to haggle about a bill, the hospital has something to give away which does not actually cost it anything.

Closing Sentence:

The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

The sentence quoted above, which appears immediately above the signature represents a radical departure from long-standing hospital practice. In standard business practice, we never advise a client to sign anything unless he gets a copy; yet hospitals for years have failed to furnish the patient with a copy of the admission form which the patient was required to sign. Actually this was a very short-sighted practice.

If the patient testifies that he was not given an opportunity to read before signing or that he was under sedation, etc., then the whole effect of the document is placed in issue and jeopardized. On the other hand, if the patient is given a copy, then the legal burden is placed on the patient to object to its provisions within a reasonable time or be bound by its provisions. Furthermore, the psychology of the hospital relationship with its patient is on a much sounder basis.

The rest of the form is standard (see illustration) except that it is not executed by the hospital as contracting party as is the case of most admission forms. This is in accordance with our basic approach to the purpose of the doc-

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A SUPERIOR METHOD OF INTRACRANIAL DECOMPRESSION

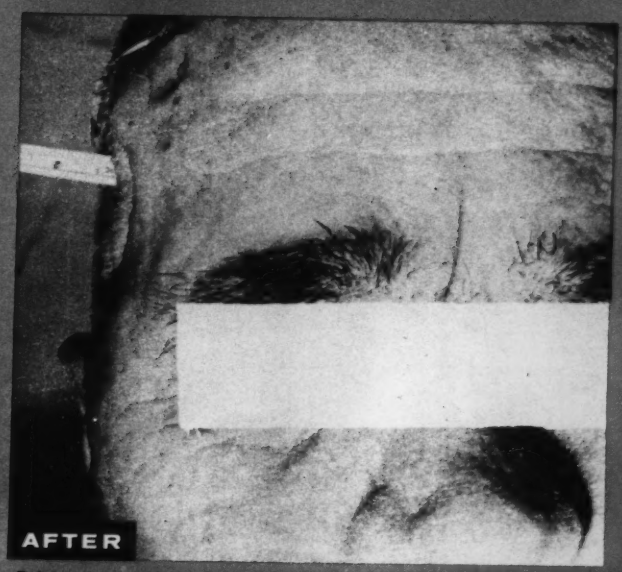
Among the numerous intracranial problems in which Urevert has been shown to be highly beneficial, reduction of a pseudomeningocele is a striking demonstration of dramatic brain decompression.

Reduction of intracranial pressure with Urevert exposes many obscure areas and often permits surgical procedures to be carried out with minimum retraction and less damage to normal brain tissue. Urevert has been described as "far superior in every respect to all other agents commonly used for this purpose."*

In depressed fractures or when intracranial pressure is acute, Urevert may be life-saving. Administered intravenously, Urevert exhibits only very occasional and relatively insignificant side effects.

*Javid, M.: Urea—New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, The Surgical Clinics of North America, Philadelphia, W. B. Saunders Company, August, 1958, p. 22.

A pseudomeningocele following the removal of a right temporal oligodendroglioma and prior to Urevert therapy.



Bulging mass completely disappears within 2 hours after the intravenous administration of 250 cc. of Urevert.

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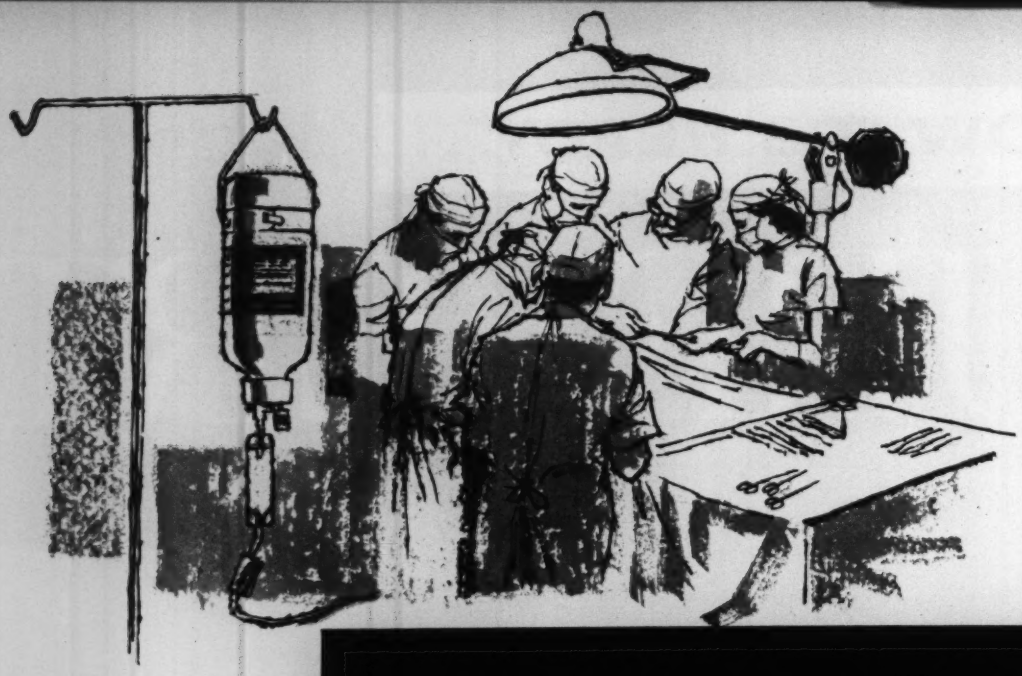
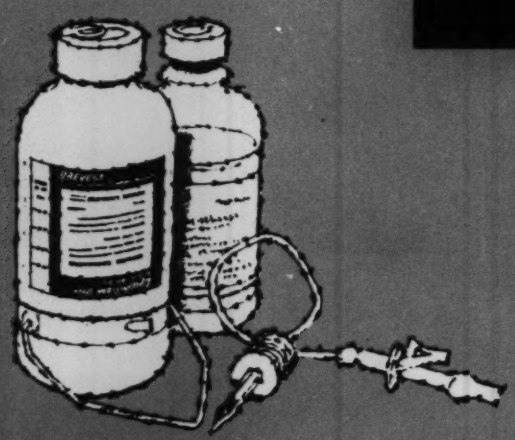


DURING INTRACRANIAL EMERGENCIES UREVERT HAS BEEN OBSERVED TO...

• Improve many prognoses	IN	Brain tumors
• Reduce severe headache		Acute glaucoma
• Enlarge the operative field		Cerebral edema
• Minimize brain damage		CNS infections
• Shorten surgical intervention		Head injuries
• Facilitate recovery		Hypophysectomy
• Shorten hospitalization		Trigeminal rhizotomy



Clinically developed during the past 3 years, the intracranial decompression achieved by Urevert* permits surgical intervention and correction in many conditions where such procedures were formerly regarded as contraindicated or technically impractical. Postoperatively, its use is more expedient than ventricular puncture or drainage.

NOTE: Complete information on the indications, dosage and clinical background of Urevert is available in a Product Brochure and clinical reprints. Write to Medical Department, Travenol Laboratories, Inc., Morton Grove, Illinois.

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*Manufactured under license from the Wisconsin Alumni Research Foundation. Patent application pending.

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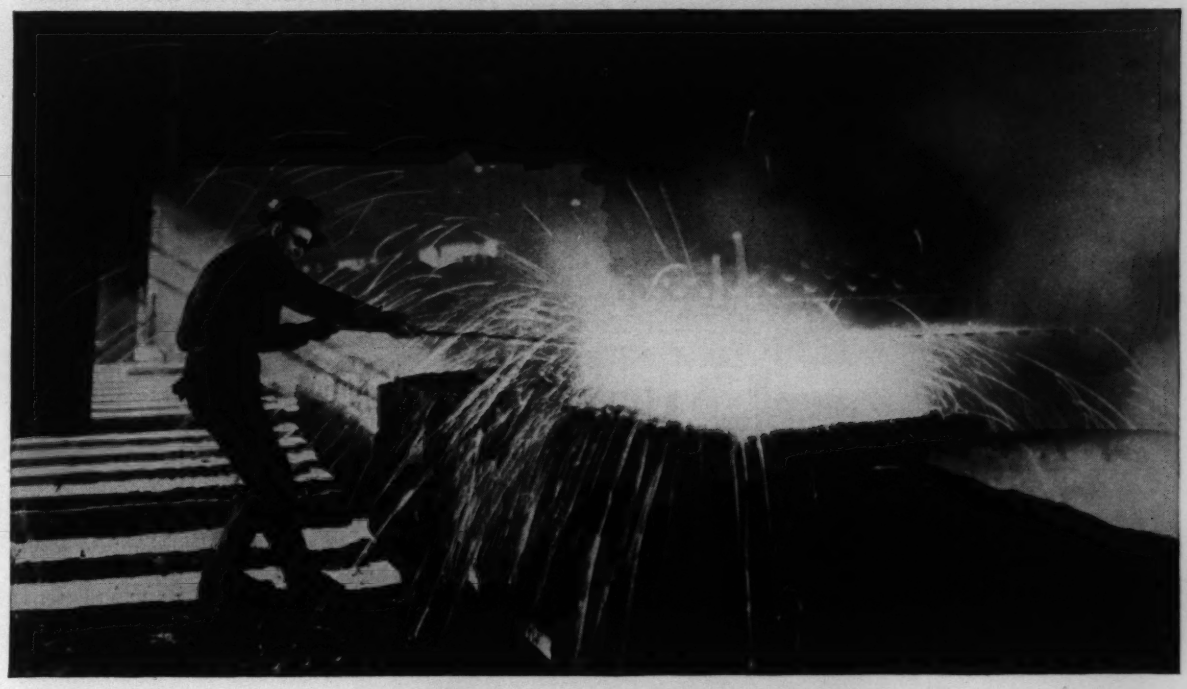

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J. K. Thomson is shown here at his work in one of the great steel mills of this country. Like thousands of his fellow craftsmen, Mr. Thomson is making regular use of his company Payroll Savings Plan to contribute to the Peace Power of his country.

HOSPITALS
Journal of the American Hospital Association

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ument, as previously explained.

On rare occasions, a patient has objected to one or more of the provisions of the agreement. We will not permit the medical and surgical consent provision to be waived, but nearly any other provision may be stricken, if the patient pays an additional dollar per day for deviation from standard policy. It is surprising how this alternative clears the air.

A little ingenuity will unquestionably improve upon the suggestions made in this article. A file is already being compiled for future changes. ■

Concepts of progressive patient care

(Continued from page 42)

The environment should be as pleasant and homelike as possible, using cheerful, bright colors, and comfortable furnishings.

Patients may be accommodated in one, two, or four-bed rooms with more space than usual for each bed unit to allow for wheelchairs or stretchers. Other features may well include handrails in corridors for assurance of support, grab bars in the toilets and bathrooms and special training toilets, day room space for a change of scenery and recreation, and a dining room to give patients an opportunity to eat with others.

Patients on this unit, as they progress, may become candidates for the self care unit, as a step toward discharge, or for transfer to the home care program, or for discharge home. A patient may also require transfer to the intensive care unit because of a critical illness or a major operation. Regular periodic assessment of this patient's condition and needs must therefore not be overlooked. The staff should be on the alert for situations where the patient is medically ready to go home but cannot do so because of unsatisfactory home conditions or lack of needed community services. The social service worker may be of help in these situations.

A group food service program established for patients in the long term care unit has a distinct therapeutic value. It can serve to minimize any physical weakness or insecurity and make the patient more self-reliant and less inclined to depend on institutional service. Provision should be made for catering to the food preferences of individuals.

Since many of the patients using the dining area in the unit may be in wheelchairs, a number of adjustable pedestal-type dining tables should be provided to accommodate them. For those patients who are bedfast, provision must be made for traditional bedside tray service.

HOME CARE PROGRAM

An organized home care program provides coordinated medical and related services to selected patients at home through a formally structured group comprising at least a family physician, a public health nurse, and a social caseworker, assisted by clerical service. Services for the patients are arranged for and coordinated through one central administrative agency. In many existing

LARGER OPERATING FIELD—A field of unusually large size insures massive wound coverage, but pattern can be easily and quickly adjusted down to spot size.

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SAFETY is not a matter of short-term trials, but determined by years of experience. A record of more than nine years of continuous treatment in a closely supervised group of patients without occurrence of serious side effects is an assurance of safety.

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If you are contemplating a fund-raising campaign for your hospital, we would like to talk further with you about it, and cordially invite your inquiry.

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FINANCIAL CAMPAIGN DIRECTION

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home care programs this is the hospital. In others it may be a health agency or social agency. In each case, the local health department can make a major contribution in helping to coordinate services.

Patients should be admitted to an organized home care program only when this kind of care best meets their needs. Skilled medical, nursing, and social evaluation are essential in selecting the patients for this program. Services should be available to private patients as well as to those whose care is paid for by welfare or other sources.

All the diagnostic and treatment services of the hospital should be available to the ambulatory patient who is able to come to the hospital outpatient department or the private physician's office. For those who are bedfast or otherwise unable to come to the hospital, certain organized services of the hospital are brought to the home.

Direct medical services to patients in the home may be provided by the hospital staff physicians who wish to participate in the home care program, including, in some programs, residents and senior medical students under supervision. Such services can include diagnostic medical examinations and uncomplicated diagnostic and therapeutic procedures. Specimens for diagnostic tests can be collected in the home. If portable equipment is available, procedures such as electrocardiograms and x-rays can be carried out in the home. Medical consultation may be made available through the hospital of which the home care program is a part.

Nursing care may be provided by the hospital nursing service, or may be a contracted service from a community agency such as the visiting nurse association. Such care may include dressings, injections, irrigations, bed baths, health instruction, teaching members of the family how to care for the patient, and helping the patient and his family plan a health program for prevention as well as maintenance and recovery.

It is often helpful to make provision for homemaker services in a home care program. Other direct services may include limited physical therapy, home teaching for children, occupational therapy and rehabilitation activities, and follow-up laboratory work.

Social services to home care patients and their families may be provided by the social service staff of the hospital or of a community social service agency. The amount and kind of services would be governed by the program of the agency and by the needs of the patient and his family. Community agency services would be coordinated with those provided through the hospital as part of the home care program.

A nurse with administrative ability, public health preparation, and a good understanding of the services available in the hospital and the community may be a suitable director of the home care program. Other personnel, whether from the hospital or from other community agencies will vary in number and kind depending on the services to be offered and on how they are organized. ■

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A "Gnup" is a **G**uy who's rapidly vanishing. (Hurray.) **N**iggles about price. Forgets quality. **U**nimpressed by the great brand names. **P**retends "it's just as good" (as Bates.)

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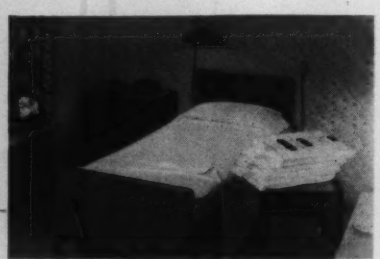

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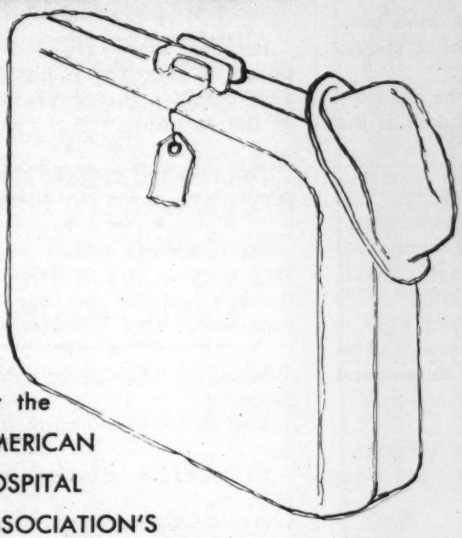

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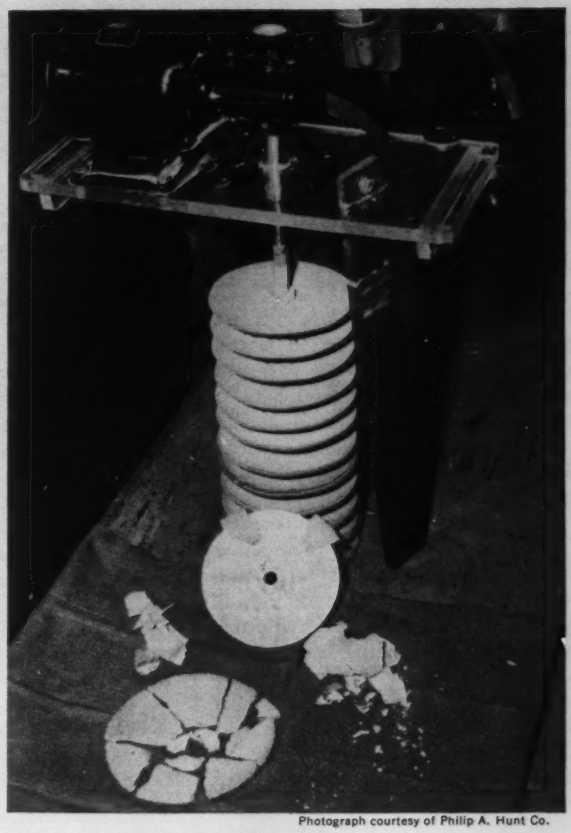

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★ ★ ★

Recipe for a hit song record: Insane lyrics, little or no tune, and a voiceless singer or singers.

★ ★ ★

Farmer Gallus says: "Somehow er other, people used ter make fust rate citizens out of their kids without worryin' 'bout whether their kids were being frustrated."

★ ★ ★

There are three wrong kinds of hospital boards of trustees:

1. Those where a majority of the members fail to realize fully the extent of their responsibilities.
2. Those where a minority of the members assume far too many responsibilities.
3. Those where there is a combination of both the above.

★ ★ ★

Members of Congress have been trying to determine what should be our national flower.

When I look at all the automobiles on the road I think it is the CAR nation.

★ ★ ★

Emanuel M. Hayt writes, "Do you think that finger printing and footprinting babies at birth will prevent our having another generation of mixed-up kids?"

I doubt it. I think that what is needed is a firmer impression about half way between the fingers and toes.

★ ★ ★

There are really only three seasons: Baseball, Football and Basketball.

★ ★ ★

Due to there being so many different kinds of employment, I suppose there will always be—at times—unemployment in some branches of human endeavor.

But there will always be people in need of sick care, in good times and bad; which makes employment by a hospital the best kind of unemployment insurance.

★ ★ ★

Perhaps there are too many people in this world; but few, if any, consider themselves as part of the surplus.

★ ★ ★

The real bill collectors are the people who never pay them.

★ ★ ★

Some doctors would starve if they were as slow in sending bills to their patients as they are in completing their histories.

★ ★ ★

More for the Moron's Medical Lexicon:

JUGULAR—Pertaining to prisons.

RED CELLS—Business deals in Moscow.

DEFENSE MECHANISM—A machine gun.

GANGLION—Leader of a lot of hoodlums.

YOU SAVE money for your hospital when you buy Gudebrod silk and cotton sutures.

Sterilize Gudebrod sutures as you need them and save **UP TO 50%** of your suture **COST.** Every improvement **IN** non-absorbable sutures is incorporated in these **SUTURES . . .** manufactured by Gudebrod for eighty-nine years.

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POSITIONS OPEN

DIETITIAN: Chief of Department, A.D.A. member or eligible for registration. 90-bed hospital with expansion program this year. Salary commensurate with training and experience. Apply Administrator, Grace Hospital, Cleveland 13, Ohio.

GRADUATE NURSES: 50 bed general, JCAH hospital. Surgical and floor duty positions open. Community of 6,000 near Kansas City. Excellent personnel policies, working conditions, and salaries. Apply J. A. Fox, Administrator, Excelsior Springs Hospital, Excelsior Springs, Missouri.

TEACHING DIETITIAN: A.D.A. Full-time faculty status; 170 students. Address HOSPITALS, Box J-18.

SURGERY NURSES: must be experienced. Beautiful 83 bed hospital in Los Angeles suburb. Excellent salary and working conditions. 5 day week. Administrator, San Gabriel Valley Hospital, 115 E. Broadway, San Gabriel, California.

DIRECTOR OF NURSES: 61 bed hospital, S. Calif., New 1958, expansion to 110 beds by Jan. 1960. Salary open. Address HOSPITALS, Box J-17.

A.S.C.P. REGISTERED MEDICAL TECHNOLOGIST: Male or Female required immediately for an 85-bed, rural J.C.A.H. Approved General Hospital, situated midway between Pittsburgh and Harrisburg; famous resort area. Salary Open, Apply Memorial Hospital of Bedford County, Bedford, Pennsylvania, or telephone the Director, Bedford 655.

Vacancy, THERAPEUTIC DIETITIAN: to relieve administrative dietitian. Beginning salary $350.00 per month, 40 hour week, with vacation, promotions and other benefits. New 166 bed hospital, excellent medical staff. Immediate opening. If interested, contact W. B. Talbot, M.D., Administrator, Butte Community Memorial Hospital, Butte, Montana.

ADMINISTRATOR: Qualified administrator for 77 bed hospital in Northern Ontario. Apply stating qualifications, salary expected and previous experience to Mr. A. Jackel, Chairman, Board of Directors, Lady Minto Hospital, Cochrane, Ontario.

CHIEF DIETITIAN: A.D.A. several years administrative experience. 650 bed fully accredited hospital. New buildings include kitchen and cafeteria. New centralized food service. First class personnel program. Excellent salary will be negotiated. Personnel Director, Albert Einstein Medical Center, York & Tabor Roads, Phila. 41, Pa.

DIRECTOR OF NURSING: Attractive salary. Duties confined to nursing administration. No school of Nursing. Beautiful location on the Mississippi River. Permanent appointment. Excellent assistant directors supporting position. Degree in Nursing Administration desirable. Apply to Stanley L. Sims, Administrator, LaCrosse Lutheran Hospital, 1910 South Avenue, LaCrosse, Wisconsin.

DIRECTOR NURSING SERVICE: $500 to $600—must have college degree with successful background of Supervisory experience. Permanent position new 108 bed general hospital. Employment July 1, 1959. Hospital opening October 1, 1959. Give full details in letter to Wm. S. Nichols, P.O. Box 235, Arlington Heights, Illinois.

BUSINESS MANAGER: $500 to $600—New 108 bed general hospital opening this fall. Must be capable of managing office staff, handle Accounts Receivable and Payable and have working knowledge of AHA Accounting Procedures. Employment by June 1, 1959. Complete brochure mailed to Wm. S. Nichols, P.O. Box 235, Arlington Heights, Illinois.

DIETITIAN: Minneapolis oldest hospital—now located in a totally new 308 bed building has immediate opening for ADA Therapeutic Dietitian. Good starting salary. Liberal vacations, sick leave, and insurance benefits. For further information contact Director of Personnel, St. Barnabas Hospital, 714 South 9th Avenue, Minneapolis, Minnesota.

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STAFF DIETITIAN: Therapeutic, A.D.A. member, hospital recently expanded to 450 beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air-conditioned; dietetic program integrated with N. L. N. approved school of nursing, affiliated with Medical Research Institute, 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

NURSE ANESTHETIST: 110 bed hospital. Available at once. Write Sister Mary Regina, RSM, Our Lady of Mercy Hospital, Mariemont, Cincinnati 27, Ohio.

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ADMINISTRATIVE POSTS: (m) Adm Asst; wk under either dir, prof adm service or dir, patient & personnel serv; 800 bd, med-schl-affild, genl hsp; coastal resort area, SE. (n) Asst Dir, personnel; new hsp organ merging 4 genl hsps; sal open; nr NYC. (o) New post; one seek'g career in Personnel wk; 250 bd, genl, vol, fully-apprvd hsp, expand'g to 550 beds; Mideast.

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NURSES, 2 REGISTERED: general duty, rotating shifts. Good salary with social security and usual fringe benefits. Location in Black Hills of South Dakota. Address: Director of Nursing Services, Homestake Hospital, Lead, South Dakota.

PATHOLOGIST: 200 bed new hospital, New York State, Salary open, Address HOSPITALS, Box J-9

TWO STAFF DIETITIANS: Capitol City's largest and newest hospital (290 adult beds-Opened 1951). Centralized Food Service-Selective menu. ADA preferred. No teaching required. $4,000 starting salary range-Liberal Personnel policies. Apply: Director of Dietetics, Charleston Memorial Hospital, 3200 Noyes Ave., Charleston 4, West Virginia.

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BOOKKEEPER: Departmental accounting experience. Fully accredited 130 bed hospital. New bldg. So. Calif. climate. Salary open. Address HOSPITALS, Box J-19.

DIETITIAN: Chief of Department; ADA member or eligible for registration. 90 bed hospital, liberal vacation. Holidays and sick allowance. Salary open. Contact Emile Wieland, Administrator, Jamestown Lutheran Hospital, Jamestown, North Dakota.

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(continued on page 148)

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ADMINISTRATOR: B.S. (Hosp Adm); 10 yrs, adm, genl, vol, hsp during which time he supervised 3 expansions plus construction of nurses home; seeks greater responsibility; early 40's.

ASSISTANT ADMINISTRATOR: B.S., Acctng; M.S., Hosp Adm; 2 yrs, Bus Mgr, 80 bed hsp; 2 yrs, Admin Asst, 700 bd hsp; nominee, ACHA; seeks Asst Dirshp, large fully-apprvd hsp; Age 33.

PATHOLOGIST: Cert'd Path Anat; Bd Elig, Clin Path; rotating internship, 1500 bd, genl hsp; 3 yrs, Mayo fellow; 1 yr, instructor, Path, State Univ; 1 yr, Path, 125 bed hospital; AOA.

RADIOLOGIST: Diplomate; 6 years as Asst Rad, 300 bed hospital; now requires warm climate.

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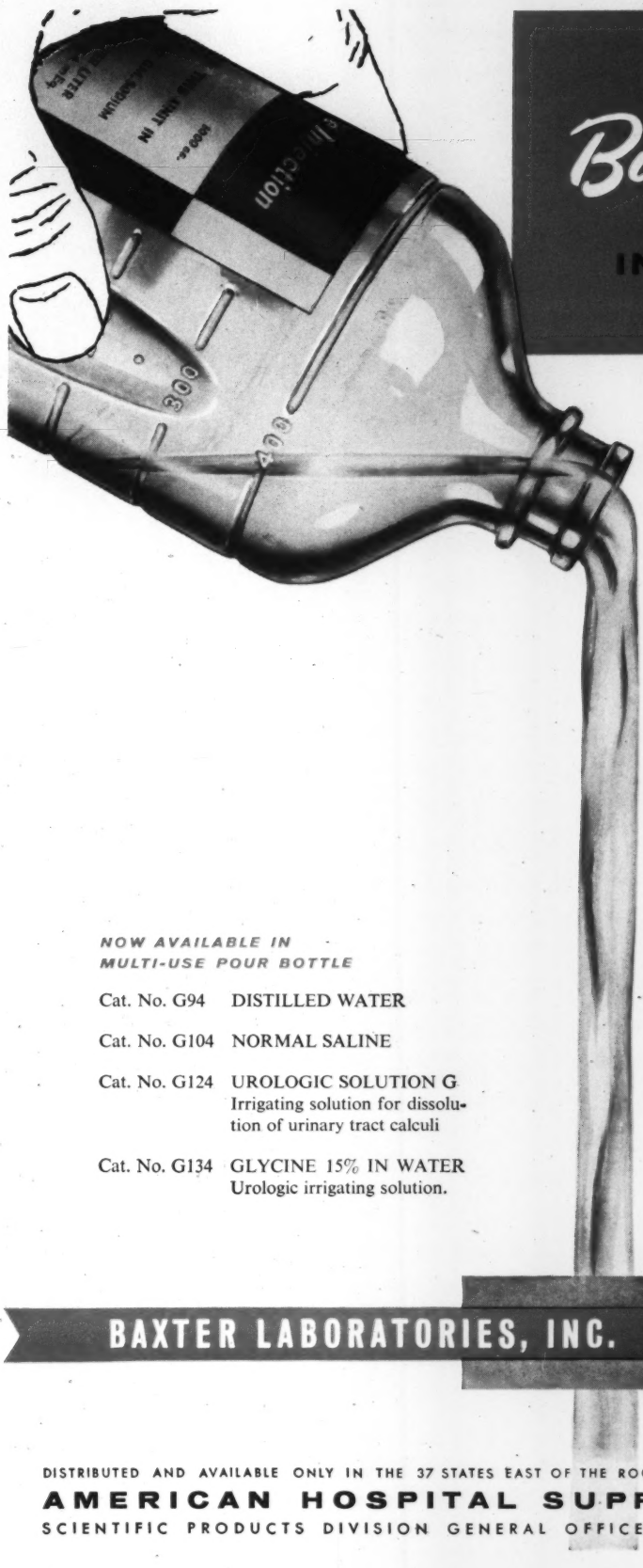

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